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FISCAL YEAR 1990 BUDGET ISSUES RELATING TO HOSPITAL PAYMENT UNDER PART A OF THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MARCH 1, 1989

Serial 101-22

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CONTENTS

Page

Press release of Friday, January 27, 1989, announcing the hearing 2

WITNESSES

Prospective Payment Assessment Commission [ProPAC], Stuart H. Altman, Ph.D., Chairman, Kathryn M. Mershon, R.N., and Donald A. Young, M.D., Executive Director 30

American Hospital Association, Carol M. McCarthy 133
Berman, Richard A., McKinsey & Co., Inc. 71
Consolidated Consulting Group, Allen Dobson 79
Dorgan, Hon. Byron L., a Representative in Congress from the State of North Dakota 17
Michel, Hon. Robert H., a Representative in Congress from the State of Illinois 5
National Association of Public Hospitals, Larry S. Gage 113
National Rural Health Association, Robert T. Van Hook 126

SUBMISSIONS FOR THE RECORD

AmHS Institute, Affiliated with American Healthcare Systems, statement and attachments 177
Association of High Medicare Hospitals, statement 183
Blue Cross and Blue Shield Association, statement 186
National Association of Rehabilitation Facilities, Carolyn Zollar, statement 189
National Committee to Preserve Social Security and Medicare, James Roosevelt, statement 193

FISCAL YEAR 1990 BUDGET ISSUES RELATING TO HOSPITAL PAYMENT UNDER PART A OF THE MEDICARE PROGRAM

WEDNESDAY, MARCH 1, 1989

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:45 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, JANUARY 27, 1989

PRESS RELEASE #1
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
FISCAL YEAR 1990 BUDGET ISSUES RELATING TO HOSPITAL PAYMENT
UNDER PART A OF THE MEDICARE PROGRAM
TO BE HELD ON WEDNESDAY, MARCH 1, 1989

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will conduct a hearing on fiscal year 1990 budget issues relating to Medicare's hospital insurance program. The hearing will be held on Wednesday, March 1, 1989, beginning at 9:30 a.m., in the Main Committee hearing room, 1100 Longworth House Office Building.

The hearing will focus on the recommendations of the Prospective Payment Assessment Commission regarding changes in hospital payments under the Medicare program in fiscal year 1990.

In announcing the hearing, Chairman Stark said, "Budget reconciliation legislation will include a broad range of Medicare provisions. Given the Congressional Budget Office's (CBO) estimate that Medicare hospital payments will increase almost 14 percent under current law, it is important that we begin our hearings in 1989 with the question of hospital payments."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

Under current law, hospital payments will increase \$8.1 billion in fiscal year 1990, not including increases in payments caused by implementation of the Medicare Catastrophic Coverage Act of 1988. This law will increase hospital payments by an additional \$1.8 billion.

The Prospective Payment Assessment Commission is required to report on March 1 of each year regarding the Commission's recommendations for the hospital payment update used to increase hospital payments in each fiscal year. This report will be presented at the hearing.

Under current law, the hospital payment update is set to equal the increase in the hospital market basket (a measure on inflation in the costs of goods and services purchased by hospitals). CBO estimates that the hospital market basket index will increase 5.4 percent in fiscal year 1990. However, in the last several years, Congress has made other adjustments in the update to take into account factors such as substitution of outpatient care for inpatient care, changes in technology, and changes in coding practices.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, March 24, 1989, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing may be submitted in other forms.

Chairman **Stark**. I am going to ask our guests and the staff if they could take their seats quietly. I apologize. The room was in use late last night and was not set up on time. So if our guests will, as I say, as quietly as they can, take their seats out of respect to our first witness, who we have had to keep waiting, we will begin the hearing.

The hearing is related to the fiscal year 1990 budget. Given the size and the rate of growth of hospital payments under part A of Medicare, it is fitting that we begin with this topic.

We are pleased to welcome Dr. Altman, the Chairman of the Prospective Payment Assessment Commission, and other distinguished witnesses to the subcommittee, which will be led off today by the Honorable Robert Michel, the distinguished Member from Illinois and minority leader of the House of Representatives.

At this point, a budget resolution has not been adopted by the Congress, and we do not know what our savings target for Medicare will be.

The administration has proposed savings for Medicare in excess of $5 billion, and in the opinion of the Chair, that is clearly too much. On the other hand, the hospital industry has demanded that we not cut Medicare part A at all, and that is clearly irresponsible.

If no cuts are made, Medicare part A payments to hospitals will grow from $61.7 to $69.5 billion, a growth rate of more than 12 percent. Even adjusting for the growth in admissions, hospital payments per case will grow 9 percent, and such growth rates are neither acceptable nor affordable.

The industry has chosen to characterize our current situation solely in terms of what they call revenue "shortfalls." Article after article in the media refer to the problems hospitals face because Medicare is not paying enough. This argument reveals how out of touch the hospital industry truly is.

Since the Prospective Payment System was enacted, Medicare payments to hospitals have grown at an average annual rate of 7.5 percent, while the Consumer Price Index has grown at a rate of only about 4.5 percent annually. I have to admit failing to see how this represents a revenue problem when payments are growing at a rate almost 1½ times inflation.

Regardless of the uncertainty about the final deficit reduction target for Medicare, I believe this subcommittee's task is clear. We need to establish tough, realistic targets for growth in hospital payments which are equitable to both the taxpayer and the hospital. In my view, that is the only way we can assure that hospitals will heed our call, moderate the excessive growth in the amount of resources they consume, and still provide quality care to the beneficiaries of the Medicare system.

I look forward to hearing from our witnesses on this important issue, and I would like to recognize the distinguished gentleman from Ohio, the ranking minority member of the subcommittee, to introduce our first witness.

Mr. **Gradison**. Well, thank you, Mr. Chairman, and thank you for scheduling so promptly this hearing on the general subject of part A reimbursement under Medicare. It certainly will be the central issue that we face in this subcommittee's work on the budget this year, although obviously there are other concerns which we will be focusing on as well.

I am particularly glad that our lead witness is the distinguished Republican leader Bob Michel of Illinois. He represents a district with an urban center and many rural counties as well, and, therefore, he has had an opportunity to see close at hand the special problems which confront rural hospitals in this new reimbursement environment.

In recent years, we have taken some steps—perhaps not fast enough—to narrow the gap in reimbursement between the rurals and the urbans. And I think it is entirely appropriate and very fitting that the our first witness will be focusing on this very special and very important problem that confronts so many of our smaller communities.

Thank you, Mr. Chairman.

Chairman STARK. Bob, welcome to the committee. It is a privilege to have you here. Any prepared statement that you would care to submit will, without objection, appear in the record in its entirety. And if you would like to proceed to enlighten us in any way you care to, the floor is yours.

STATEMENT OF HON. ROBERT H. MICHEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. MICHEL. Thank you, Mr. Chairman and members of the committee. I appreciate having the opportunity to testify today on the issue of Medicare reimbursement for rural hospitals. It is particularly pertinent to discuss this issue at a hearing devoted to the prospective payment system, the overall method of reimbursing hospitals under Medicare.

As you know, I have introduced a bill, H.R. 804, entitled the "Fair Medicare Treatment for Rural Hospitals Act of 1989." The bill would equalize Medicare reimbursement rates for rural and urban hospitals and requires that the equalization take place without any increase in total costs.

I should say at the very outset, Mr. Chairman and members of the committee, that some of you old-timers may recall that prior to my becoming Republican leader, I served in a more active role on the Appropriations Committee in the field of health, education and welfare. I knew my subject pretty well. Part of the problem of becoming a leader is that you are a jack-of-all-trades and a master of none. So I would certainly have to defer to the committee's judgment on many of these issues. But still having that lively interest in what I once thought I knew very well as a subject matter, I will do my best here to alert you to a problem I have been confronted with. And I think any Member of Congress with a widespread rural district—mine happens to encompass 16 counties—is probably experiencing similar problems. While in my large urban center of Peoria the health care industry is the second biggest employer next to my dominant industry of Caterpillar, it is nevertheless a different dimension when you get out into the rural communities.

We introduced this legislation in an effort to help alleviate the economic crisis facing many of our rural hospitals. I have had one that has had to close down; two others are facing severe financial difficulty. I guess if my figures are correct, nationwide over 160 rural hospitals have closed in the past 8 years, and another 600 of the Nation's 2,700 rural hospitals are in danger of shutting down.

Statistics can point out the magnitude of a problem, as these do, but they are also rather impersonal. When we look at the human impact of the loss of a rural hospital, however, we see the tragic results and hardship that takes place. It is particularly true for the elderly who often comprise 50 percent or more of the patient load in our rural hospitals.

When a hospital closes down in a rural community, the elderly are often faced with having to travel great distances to obtain care. That is difficult for older people as it is, but when they become ill, then it becomes insurmountable.

I have instances of elderly citizens in my district having to make these round trips of 100 miles or more to get to a near-by hospital. It is a considerable hardship for them.

When they close—when a rural hospital closes down, doctors, and health care personnel disappear along with them. In Beardstown, Ill., where the hospital recently closed, there were eight practicing doctors when the hospital was open, and now there are only three.

The Medicare reimbursement rate is a major element in the economic viability of rural hospitals because, as I indicated earlier, Medicare patients represent a high percentage of the patient load and, therefore, revenue source, of most of these hospitals. When Medicare patient loads run as high as 50 to 70 percent, considerably higher than for many urban hospitals it is obvious that the Medicare payment represents life and death for many of these hospitals.

When the urban/rural differential was initially established, conventional wisdom held that rural costs were less than urban costs, and therefor the reimbursement rate should be less.

However, I believe operating costs vary more by region of the country rather than between urban and rural. Equipments, supplies, fuel and overall overhead in any one State are as costly in rural areas as they are in the urban areas. Personnel costs, as they involve the cost of living, might be conceivably be lower in some rural areas, but that is off-set by the difficulty of recruiting trained medical professionals to rural communities and the corresponding need for good salaries to attract and retain these individuals.

The fact that Congress has in recent years reduced the reimbursement differential between urban and rural hospitals indicates a recognition, I believe, that rural costs are now approaching, if not exceeding, those in urban areas. But we are still reimbursing rural hospitals an average of 13 percent less than their urban counterparts, and that can be a life or death matter for many, including the ones with which I have come into contact.

I can say that quite frankly after having discussed the issue with rural hospital boards of directors, comprised of very dedicated people who are just absolutely frustrated in seeing that they can no longer keep their small hospitals open with no place to turn.

So, I think the time has come to fully equalize the rate of reimbursement, and the bill that we have introduced would do this simply by eliminating the existing differential. Other bills have been introduced to accomplish the same objective through somewhat different means, and I am not wedded to any one approach, but I think it is important that we make the change.

I hope that this subcommittee will actively consider the issue this year, and certainly thank you for the opportunity to make this case today.

In conclusion, when you think in terms of the numbers, rural hospitals versus urban, or the number of patients served in each case, that whatever you take away from the urban hospitals to equalize the rate the rural hospitals is going to be rather minuscule. You folks know the figures better than I do, but I have a hunch that it is very minute and could be very well accomplished without additional budget outlay.

I thank the committee for its attention, and I will be happy to respond to any question you may have.

[The statement of Hon. Robert H. Michel follows:]

Testimony by Robert H. Michel
on H.R. 804, the Fair Medical Treatment
for Rural Hospitals Act of 1989
before the Subcommittee on Health
House Ways and Means Committee
March 1, 1989

I appreciate having the opportunity to testify today on the issue of Medicare reimbursement for rural hospitals. It is particularly pertinent to discuss this issue at a hearing devoted to the Prospective Payment System, the overall method of reimbursing hospitals under Medicare.

As you may know, I have introduced H.R. 804, entitled the "Fair Medicare Treatment for Rural Hospitals Act of 1989." The bill would equalize Medicare reimbursement rates for rural and urban hospitals, and requires that the equalization take place without any increase in total costs.

We introduced this legislation in an effort to help alleviate the economic crisis facing many of our rural hospitals. In my district, we have had one rural hospital close down, and two others are facing severe financial difficulty. Nationwide, over 160 rural hospitals have closed since 1980, with another 600 of the nation's 2700 rural hospitals in danger of shutting down.

Statistics can point out the magnitude of a problem, as these do, but they are also impersonal. When we look at the human impact of the loss of a rural hospital, however, we see the tragic results and hardship that takes place. This is particularly true for the elderly who often comprise 50% or more of the patient load in rural hospitals.

When a hospital closes down in a rural community, the elderly are often faced with having to travel great distances to obtain care. That is a difficult task for older people as it is, but when they become ill, it can be insurmountable.

Wylma Schall, a 75 year old woman living in Virginia, Illinois, had to travel 100 miles round trip to Springfield, Illinois for tests following closure of the nearby hospital in Beardstown. Because of her age, she had to find someone to drive her. This was a considerable hardship for her, and while things worked out in this instance, they easily might not in other instances.

Hospitals are also the key to overall health care in many rural communities. When they close down, doctors and other health care personnel disappear along with them. In Beardstown, there were eight practicing doctors when the hospital was open. Now, there are only three.

The Medicare reimbursement rate is a major element in the economic viability of rural hospitals, because as I indicated earlier, Medicare patients represent a high percentage of the patient load — and therefore, revenue source — of most of these hospitals. When Medicare patient loads run as high as 50-70 percent, considerably higher than for many urban hospitals, it is obvious that the Medicare payment represents life or death for many of these hospitals.

When the urban-rural differential was initially established, conventional wisdom held that rural costs were less than urban costs and therefore the reimbursement rate should be less. However, I believe operating costs vary more by region of the country rather than between urban and rural. Equipment, supplies, fuel, and overall overhead in any one state are as costly in rural areas as urban areas. Personnel costs, as they involve the costs of living, might conceivably be lower in some rural areas, but that is offset by the difficulty of recruiting trained medical professionals to rural communities and the corresponding need for good salaries to attract and retain these individuals.

The fact that Congress has in recent years reduced the reimbursement differential between urban and rural hospitals indicates a recognition, I believe, that rural costs are now approaching, if not exceeding, those in urban areas. But we are still reimbursing rural hospitals an average of 13% less than their urban counterparts, and that can be a life-or- death matter.

So I think the time has come to fully equalize the rate of reimbursement. My bill would do this simply by eliminating the existing differential. Other bills have been introduced to accomplish the same objective through different means. I am not wedded to any one approach, but I think it is important that we make the change. I would hope that this Subcommittee will actively consider the issue this year, and I thank you for allowing me to make the case today.

###

Chairman **Stark**. Thank you very much.

Mr. Gradison.

Mr. **Gradison**. I have no questions, Mr. Chairman, and I do want to thank Mr. Michel for making a very powerful and effective statement on an extremely important issue which does not only merit our attention but deserves action this year.

Thank you.

Thank you, Mr. Chairman.

Chairman **Stark**. Bob, I have a problem that I want to share with you because many of us on this subcommittee share the same problem that you do.

It is my guess, and our staff's best estimate, that if we took your bill literally without spending any more money, which maybe some of you would like to do if we had it, we would almost require a 2 percent cut for your hospitals in Peoria and Beacon.

And I believe—and I think you would agree with me—they are not going to like that. Now, let me go nationwide on the rural issue. I am going to make a statement that is an opinion here. The rural hospitals—that you are concerned about and many of us on this committee are—are not suffering from a per case cost for a reimbursement problem, they are suffering from too little volume——

Mr. **Michel**. That is right.

Chairman **Stark**. So even if we raise the amount we pay per procedure to them, they are not going to get their volume. Some of their numbers come this way. Here is the political problem we are all going to face.

In the rural hospitals the average occupancy is running about 40 percent. Less than 5 percent of the rurals have an occupancy rate over 60 percent. Ninety percent of them are within 35 miles of another hospital. And 75 percent are within 25 miles of another hospital.

Now let us just assume that one of the solutions here is that some of them become nursing homes or clinics without the full acute care. Some may have to close. Do you want to close them in your district or do I close them in my district? As we go through this process, if we take the position that we cannot touch anyone of them, we are going to hurt them all a little bit.

That is the problem facing the subcommittee as we go along. I know because of your interest in this issue and of the problem in your district. You have both. I do not know how we do this on a national basis without creating some problems.

And your patience with the subcommittee would be appreciated.

Mr. **Michel**. Well the chairman makes a good point, and the first question I have asked our hospitals is, what is your occupancy? Well, if there are only 17 patients in a 40 bed hospital, obviously there is a problem.

But, their answer to that, of course is the fact that they do not want to have an inferior grade of service as distinguished from the urban center. Everybody is well enough informed now out in the far reaches of the country to know what is good, what is the best, and what is somewhat inferior.

But, I just offer this as a possible suggestion to alleviate it in part. I am reminded of how years back everybody wanted a veterans hospital in their community, and we said we cannot afford that. We now have a VA clinic—an outpatient clinic in Peoria that is doing a very fine job. We have many of those around the country serving the needs even though they are somewhat less than a hospital.

Maybe, as we move along in rural America we are going to have alter our sights to go that route as distinguished from—as you say—trying to take care of the few at the expense of all and then bringing the whole system down. I have no perfect answer, Mr. Chairman, other than I think it is time that we bring it to the Subcommittee's attention, particularly when you are on this subject and to take it into your deliberations. And if there is some answer, fine. If not, we have given it our best shot.

Chairman STARK. I appreciate the minority leader's patience with us in understanding this problem because it is only going to get thornier as we wind through the budget problem this year.

Before I recognize Mr. Coyne to inquire, next to leaving your headlights on probably the most dangerous thing that any member of the audience could have done was to leave their coats on the racks in the halls outside because if you do not get up right now and retrieve them they may be gone.

In deference to the witness, as you go to get your coats which you left in the hall on the racks, would you do it quietly so as not to disturb the proceedings?

Mr. Coyne, would you like to inquire?

Mr. COYNE. Thank you, Mr. Chairman.

Mr. Leader, I guess in the ideal world, if we were to eliminate the differential, that would be well and that is something that you advocate in your testimony. But in the meantime, I wonder what weight the committee ought to give to the fact that rural hospitals send many of their elderly and sick people to urban hospitals when they do not have the equipment or the wherewithal to conduct the necessary service for them. Is that something that you think the committee ought to consider when evaluating reimbursements?

Mr. MICHEL. I am quite well aware of that because, as I indicated, in my home community the second largest employer now is the health care industry. We have three hospitals, a medical school and the very finest open-heart surgery and the whole gamut of things.

I guess it is always a question of how much of a burden we should ask our senior citizens to bear. As you know, that group in the rural communities keeps getting larger all of the time with people now living into their eighties and ninties, and with limited incomes feeling that rural areas are more reasonable place to live. But we also know that there is an accompanying medical problem that compounds itself because of the ever increasing number of aged citizens that are residing out there in rural America, and cannot afford the means of traveling 50 miles each way to a hospital.

As I indicated it is a frustrating problem. I do not know if I have the total answer other than to make the case the very best we can. We can at least provide the minimal of services in those rural communities.

Mr. COYNE. Thank you.

Chairman **Stark**. Mr. Crane.

Mr. **Crane**. I do not have any questions, Mr. Chairman. I simply want to congratulate our distinguished minority leader for his testimony, and as one who has lived in his district for a number of years, I can attest at least to the quality of care at the urban hospital they have down there. Three of our children were born in Peoria.

Thank you, Mr. Chairman.

Chairman **Stark**. Some others were born, as I recall.

Mr. Levin.

Mr. **Levin**. Thank you, Mr. Chairman.

Just briefly, I join in welcoming the distinguished minority leader.

I think that the data you presented, Mr. Chairman, really painted the dilemma here. I think there is a tendency to look upon Members of the House as urban or rural—it does not matter which side of the aisle. If they come from an urban area, they vote that way. If they come from rural area they vote that way. We tend to forget that some people represent both, and that others who may represent one or the other try to view things a little more broadly than that.

I do not think that there is a prejudice here among those of us who come from urban or suburban areas against rural hospitals at all. Some months ago I went with Bob Traxler to thumb of Michigan to look at the situation and to hear people from rural hospitals, and I think what you say is so true that statistics can point the magnitude of the problem, but they are also impersonal when we look at the human impact.

We see the tragic results; when a hospital closes in a small community it may mean a rather long travel distance.

But, I think that the statistics show the dilemma. I am afraid that simply evening out the payments would have a major budget impact. And if you look at the President's proposal it already has a deep cut into hospitals.

So, I would like to echo the sentiments of the Chair that we would like very much to work together on this. It is going to involve some excruciating decisions, and it may mean at times taking on the budget proposals.

Mr. **Michel**. The gentleman makes several good points. I am aware, of course, that the reimbursement for Medicare patients is somewhat less than 100 percent of the total cost. Medicaid in Illinois is even less.

So, we know we are not fully reimbursing hospitals, and—I have even gone to the State and asked if there is a possibility we can have the State fill the gap here. I see Mr. Dorgan, sitting on this subcommittee, who of course comes from a district with many rural areas that may very well have the same problem compounded as I have, but at least if we get the issue here in the public arena addressed openly, maybe the folks out there will recognize a little more seriously the problem we are confronted with here.

It may be necessary to say I am sorry, we have no alternative, but for you to have to go so many miles to the urban center for that best kind of care. It would be kind of tragic, but maybe that is where we are heading.

Mr. LEVIN. Thank you, Mr. Chairman.

Chairman STARK. Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman. Welcome, Mr. Michel.

The problem we have on this subcommittee and in the Ways and Means Committee is that there are very few of us that represent largely urban versus rural hospitals. I happen to represent all rural hospitals, and I can promise you in the markup 2 years ago it was contentious, it was argumentative, and it lasted for about 15 days so that we can resolve it.

And, basically what you have got is a big money pie that has been shrunk and shrunk and shrunk over the past 8 years with each component part striving to get more and more out of it. So you create these enormous conflicts politically between Mr. Levin, Mr. Donnelly, Mr. Coyne, even the chairman representing the larger hospitals in California.

So I must tell you it is refreshing to hear you come in and say you are concerned about rural hospitals and you want to work with the committee and the Congress to do something about it.

Being the minority leader, I think we can work on a bipartisan basis to try to solve this problem. But I tell you it is not going to be easy, and we are going to have some real, real, tough fights.

I would just like to test some ideas that I have been working on to see if you are supportive of these or if you have given them any thought. One, without question the urban/rural differential that you have mentioned in your testimony is the culprit—bar none, that is the culprit. And I have cosponsored a piece of legislation along with Mr. Pickle and others that would eliminate this differential, and I wondered if you support the elimination of this differential?

Mr. MICHEL. That is the thrust of what I am really talking about today.

Mr. ANTHONY. So, you would be on board and you would try to work with us to solve that particular problem?

Mr. MICHEL. Absolutely.

Mr. ANTHONY. Knowing that this creates an enormous political problem for the larger hospitals, particularly teaching hospitals where the money would probably be taken away from?

Another area that has given me a great deal of concern is the area wage index. I do not know if you have run into this or not, but in my area, as the chairman has testified, some of our rural hospitals are within 35, 40, or 50 miles of some of the large urban hospitals. I am not sure how they can do this, but the labor people can come in and draw this magic line and say if you work and live in this area you are going to be paid—in my area—43 percent less if you live below that line. Yet, those hospitals are competing for labor back and forth.

My hometown is only 18 miles from the Louisiana border. Monroe is 90 miles away in one direction, and Shreveport 90 miles away in another direction. They actually come and rent motel rooms in my home town to recruit and steal away our competent nurses because there is a shortage of nurses. They are able to pay them 43 percent more wages because they are better reimbursed by the Federal Government through the Medicare system.

That is unfair.

And I just ask would you help me and try to eliminate and straighten that out?

Mr. **Michel**. I share the gentleman's concern because we have had a little bit different aspect of that happen.

I seem to recall that it was in the reconciliation bill a couple of years ago when we attempted to do something about this disparity by saying that counties adjacent to urban areas would be reimbursed at the urban rate. Well, that is all right, but if you do not expand that adjacency to additional counties, then eventually you get backed into the corner where you and I find ourselves, and it has not been the answer for us.

Mr. **Anthony**. No, it has not been the answer for us. As a matter of fact every member of the subcommittee got up and went back home and called their hospital administrator and said can you give us a definition to put our hospital within that definition?

It was a terrible way to legislate, but that is a problem we need to work on.

I must admit that I am pessimistic, and I do not think we are going to pass legislation quickly enough to save some of the hospitals that are already working into their capital and their reserves. They have chosen to go into their reserves rather than close down early. I know hospitals in my district that have 18 months of reserves left. When they spend it they are going to shut down.

So if we do something we need to do it immediately, and we need to make it retroactive so that they can get some relief.

For those that do close down, we are going to have to find something that is going to be different. I have been trying to talk about transportation as part of the Medicare system in order to transport the elderly so that they can have access to good health care delivery systems.

I would like for you to take a look at that and see if you would like to throw your support behind putting a transportation component for rural citizens into the medicare system. Right now you have to be in an ambulance being delivered to the hospital before it is covered. If you are put into a taxicab or a friend's car or a family's car, and they charge you $10 or $15 to get there, that is not a reimbursable expense.

It appears to me not to be fair.

How do you feel about something like that?

Mr. **Michel**. Well, I would be happy to take a look at that one because I think there are some areas closely akin to that where we are currently providing transportation. It is not all that far fetched to go one step further. I would certainly want to take a look at it.

Mr. **Anthony**. Chairman Stark mentions that some of them may be forced to close in terms of being hospital and maybe turned into a nursing home, or some other type of health care delivery system.

What disturbs me is that just because these people make a free choice to have either moved into a rural area or not a free choice by having been born into rural area and choose to stay there. Documentation shows that they are poor and older, and basically they are on Medicaid rather than Medicare. And that is the reason your hospital only has 17 beds occupied rather than the 40.

With the Peer Review and the PPS, the pressure is on them not to put them in the hospital because they know they are going to lose money so they try to find an alternative.

But at the same time I do not think we need to go to the big cities be they in Mr. Levin's district in Pennsylvania or in Mr. Coyne's district in Michigan to get all of these fancy services. We need to find some way to bring more of these doctors and these trained technicians out into the rural areas because it is emotionally draining to try to transport and move these people into very strange areas.

So, I would also ask you to take a close look at how we might develop some way to move and transport these people on a short-term basis to deliver the skills and then return and go back.

And, finally I will touch more on what Sandy said. Taking your testimony is good, but if you end up supporting President Bush's budget, then you are going to have to go back and tell your rural hospitals that your form and rhetoric are against them in principle because $400 million will be taken away from our rural hospitals if President Bush's Medicare budget is passed. And that comes on the top of 8 consecutive years of Medicare cuts under Ronald Reagan.

So as a minority leader I would ask you to extend your hand in cooperation in a bipartisan way, and let us see if we can stop this hemorrhaging and see if there is some other way to balance the budget and not balance the budget on the backs of the poor, sick in rural areas.

Mr. MICHEL. I understand what the gentleman is saying.

Mr. ANTHONY. And I will have a lot more to say about that later on.

Chairman STARK. It is now my pleasure to recognize the newest member of our subcommittee, on her maiden voyage with this subcommittee, the distinguished gentlewoman from Connecticut, Mrs. Johnson.

Mrs. JOHNSON. Thank you very much, Mr. Chairman.

Chairman STARK. Welcome to the Committee.

Mrs. JOHNSON. Thank you. I am honored to be a member of this committee. It certainly has before it some of the most important work—one of the biggest challenges that the Congress faces, and I am very pleased to be a part of it and appreciate the good leadership that you and my colleague from Ohio have been providing for the committee.

And welcome, the gentleman from Illinois, our distinguished minority leader. I am going to ask you just a couple of brief questions. I don't know whether your conversation with your rural hospital extends to this, but I wonder if they happened to mention to you what percentage of those 17 patients were Medicare?

Or what their average Medicare census was for their occupied beds? And if they mentioned to you any other cost drivers that they feel Government is blind to? For instance, does a hospital of that size conform to the Centers for Disease Control requirements or recommendations in regard to protections against AIDS spread, which is very costly and would be very costly to a small institution like that.

Did they mention to you either the proportion of or the percentage of their patients that have——

Mr. MICHEL. I think it was somewhat over half. Somewhere between 50 and 70 percent.

Mrs. JOHNSON. That's about the percentage that I am finding in my rural hospitals in Connecticut—60 to even 70 percent being Medicare dependent. Next year, if we adopted no cuts in Medicare, we would be down to paying 75 cents on every $1 of care for at least 25 percent of our hospitals.

We are facing, in my estimation, a real crisis. Not only are probably 60 percent of those patients Medicare dependent, but viewed from the prospective of the changes in PPS which you put in place a very careful oversight of who gets admitted leads to sicker patients. The patients who are getting admitted also need a much more intense level of care than they did 5 years ago or 10 years ago, and I think that has to be considered in the cost equation.

Mr. MICHEL. I will say to the gentlelady, you know, the supplies for example, they are purchased from the very same suppliers used by the urban hospitals. There isn't a differential there. I think what we were talking about, in times past, were the wage rate differentials, but even those are not all that disparite anymore.

Oh, perhaps you can find a few hospital attendants working for lower wages than those in the big city, but there just isn't that kind of differential component that we perceived earlier on existing today. And so that's what puts them in that dilemma.

Mrs. JOHNSON. I agree with you. And that's been my experience as well, that there isn't a justification for that differential. Has there been any consideration in your district by these small hospitals as to what kind of facilities they might turn into, to meet some of the medical needs of their communities?

I give you as an example, a change that is taking place in the VA system for exactly the same reasons—budget pressure—that is resulting in one of our hospitals becoming sort of a super outpatient clinic with some inpatient intermediate bed care capability, but all of the surgery, the sophisticated stuff, going to the other VA hospitals.

Has there been any thought among your rural hospitals as to what kinds of facilities they could become? Could they reduce their beds to say 10 and become an outpatient facility? Should we be looking at, in your estimation, a kind of a beefed-up reimbursement level that is higher than the amount for clinics, maybe something like ICF level of reimbursement? Or should we create some new reimbursement level for rural clinics with a holding capacity that somehow is longer term than emergency room care, but doesn't try to provide more sophisticated kinds of surgery and long-term surgical care.

Mr. MICHEL. I don't see the kind of initiative in the case of the hospitals in my district currently experiencing financial difficulty. But I can recall a situation several years ago in another one of my counties, Tazewell, where a very enterprising doctor and entrepreneur, Idlow Russi, established a facility along this line without any Federal assistance.

Of course, now he has his fair share of Medicare and Medicaid patients, but also in addition to that, an alcoholism treatment, drug rehabilitation center in conjunction with it where there are patients eager and anxious to kick the habit.

Ingenous steps like this take movers and shakers to make them go, and it is all the better if there are several in a community. Unfortunately, in a very poor community, if the most talented and capable people leave, that resource gets lost and it is lost forever. And then you are playing catch up all the time.

Mrs. Johnson. Well, thank you very much for being with us this morning on this really important topic. Thanks.

Chairman Stark. Mr. Donnelly.

Mr. Donnelly. Thank you, Mr. Chairman. Bob, I'm looking at the clock and knowing how busy your schedule is as minority leader, I am sure you've fallen a half an hour behind. I appreciate you coming by. Being from urban America, I have a thousand questions to ask you, but I do agree that there is a problem.

I am not necessarily sure that your solution is the solution and we'll work with the people that represent rural America and see if we can put some equity in the system and appreciate all of the time that you have given to this subcommittee and the expertise you bring here this morning.

Mr. Michel. I appreciate the indulgence of the committee in hearing me out on this problem. I think what I have said represents the feelings of a good many other Members who represent rural areas like I do and who find ourselves unsure of what kind of solutions to provide.

Chairman Stark. Mr. Pickle.

Mr. Pickle. Mr. Chairman, I don't have any questions. I appreciate the gentleman's testimony and the leadership that you give to the Congress and this committee on this issue. I make this observation. If, in fact, cost of rural hospitals are just as high as the urban hospitals, then we should close the differential in payment. I think those facts have got to be established. I don't know that we know that yet.

We all assume it. But I don't know that I have seen the facts. Secondly, if the facts show that, that alone won't keep the rural hospitals operating. I have just as many rural hospitals as you have. The second fact is the hospital in rural areas have got to be used. They have got to be filled by people of that community. And if they don't want to do it, no matter what we do to it, nothing we do on the rate will be a sufficient answer.

I am convinced there is a problem here and we ought to take some approach along your lines or lines I've introduced or Mr. Dorgan and others. But I think those facts have got to be shown. Do the facts show that costs are similar and if so, then close those gaps and secondly, remind the patients in rural communities that they've got to use their hospital or else it can't be kept open. Thank you for coming.

Mr. Michel. Thank you.

Chairman Stark. Are there any other members? Mr. Dorgan.

[No Response.]

Chairman Stark. If there are no other members who wish to inquire, I would like to thank the distinguished gentleman from Illinois for joining us today.

Mr. Michel. My thanks to your taking the time to be with us this morning.

Chairman Stark. Thanks a lot, Bob.

Our next witness is a member of the committee, a distinguished colleague from the State of North Dakota, Mr. Dorgan. As always, we will look forward to you enlightening us and you may proceed in any manner you wish.

STATEMENT OF HON. BYRON L. DORGAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH DAKOTA

Mr. DORGAN. Mr. Chairman, thank you very much. Let me state at the beginning, the reason that I have asked to testify before a subcommittee of a committee on which I serve is that many of us who come from rural America have been patient almost to a fault with this new Medicare reimbursement system. We need to make some changes and we need to make them soon, particularly for the health of rural America hospitals.

Let me tell you just a very brief story, if I might. When I was a young man, my father ran a machine shop and a fellow named Pete Christman, from my hometown, a town of 350 people was out working on his combine, outside of the shop. He cut off all four of his fingers in a sprocket and chain.

As he was standing there holding his hand my father told me that I should pick up Pete's fingers and put them in a rag. We put Pete in the car and I held Pete's fingers in a rag on my lap while my dad drove about 80 miles an hour to the nearest hospital, 50 miles away. Pete was in need of some health care at that time. But the nearest health care for Pete, who lost all of those fingers in that combine, was 50 miles away. Incidentally, the fingers weren't any good when I got them to the doctor. The doctor wondered why I was carrying them. The nearest health care for a fellow that suffered that trauma was to drive 80 or 90 miles an hour for 50 miles to find a hospital for him.

I represent a State that has 680,000 people and it is the size of 10 Massachusetts in landmass. We have rural hospitals spread out around that State. I can tell you that the access to health care is much, much more important than cost. Folks need a place to go get health care in rural America.

It is alarming that many of our rural hospitals are suffering an enormous financial pinch and we are seeing more and more hospitals close. We will see many more close in the years ahead unless we do something about it. The perspective payment system which is based on the law of large numbers, is contributing to the financial crisis of rural hospitals.

I can recall sitting over here on the committee when the Secretary of HHS came and presented this program and he said essentially that PPS deals with the law of averages. Somebody gets sick with a problem that is diagnosed as the number "X" problem, whatever that might relate to. The PPS system assumes that on average, a hospital ought to be reimbursed to a certain level. Now some hospitals might cost more to treat that, some less and so those whose costs are greater are persuaded to bring their cost down and those who have lesser cost are rewarded. But you deal with laws of average here and the problem with that in rural areas is that you don't have sufficient averages.

A hospital with 500 beds and higher numbers or admissions discharges is almost like frying hamburgers at a hamburger stand. You've got large numbers and your losses and profits average out. But a hospital with 22 beds and 12 of them full, does not have averages.

The law of large numbers means that you win some and you lose some. If you don't have the averages and you suffer a big loss, you are in desperate trouble. That has always been the problem in the prospective payment system and how it applies to rural hospitals.

One final point that I think is most important. We were promised when this system was passed, that there would be a national rate. That wasn't just a contention, that was a promise. There was going to be a national rate and so I and others who represent rural hospitals felt that we could accept the nine regions and other things as an interim step to get to that point.

But we have never gotten to that point. And every year we find people who believe that we ought to shudder step or walk in place at least and avoid getting to what we were promised. That is the national rate. Mr. Pickle said it well, we need to eliminate the differential. If we are going to provide the kind of health that we need to provide to rural hospitals to keep them open, we are going to have to eliminate the differential.

Now, Mrs. Johnson said that hospitals in her district have a 60 or 70 percent Medicare dependency rate. Rural hospitals in small communities in my district, find that their patient loads are in the most cases, around 70 percent Medicare patients. When people are coming in for health care in those hospitals, they're old folks. Medicare patients.

If anyone of us were the administrator of a rural hospital—it would be interesting if all of us were trying to administer a rural hospital—we would understand the severe financial impact of having 70 percent of the people coming through our front door being Medicare patients. We would also understand the frustration that 70 miles away in a little larger town, hospitals are being reimbursed much more for the same type of patients. We would know the kind of money we are losing and how difficult it is trying to figure out how to keep the doors open.

There is something wrong with that system. Fortunately, it is something that we can correct if we have the will to do it. Mr. Donnelly pointed out it takes money, as did Mr. Anthony. I don't disagree with that. Mr. Anthony talked about getting a bigger piece of the pie. Maybe we have to bake a bigger pie here. If there is not enough money to serve the needs, then we have got to bake a bigger pie.

Someone who recommends a $5 billion cut for Medicare at a time when more and more Americans every single month are coming onto the Medicare rolls, is saying let's provide a new tax. A $5 billion Medicare cut is a tax by another name. Particularly it is a tax on the old folks. In general, it is a tax on everybody, because somebody will have to pay what the Government won't in its contract on Medicare.

One final point, Mr. Chairman, I had a woman stand up at a town meeting that I was holding in a small community in North Dakota. This was a meeting in which almost everybody talked about the need to cut Federal spending. This woman stood up and said that she wanted to compliment us on the Medicare system.

She said, "I just had cataract surgery" and she said "Last year I got a new hip and the year before two new knees." She said, "I feel like a million bucks." A 75-year old woman. And the crowd felt wonderful for her. And I said, "30 years ago you wouldn't have come to our meeting because you would have been in a wheelchair. Even if you would have been here, you probably wouldn't have seen me. But think of it, today you have cataract surgery, a new hip, two new knees and you feel great. I want everybody in this room to understand what it cost for you to feel that way." The Medicare program is extraordinarily expensive. It's wonderful. It's a miracle what we do in medicine, but it's very expensive and we all had better understand that and be willing to pay for it.

We are saying that we are not willing to pay for it when we say that we agree to a $5 billion cut, even though we have an avalanche of new people coming on the roles each year. The policy that says that those hospitals most vulnerable, those hospitals most fragile are the ones that are going to get the smallest reimbursement for the services provided to their population of elderly is saying that we are not willing to pay.

That is fundamentally wrong. I might just say that those of us who come from rural America and represent especially rural hospitals on the Committee, have really lost patients. We are going to be much more assertive in this Congress than in past Congresses, because we want the Federal Government to keep its promise.

The promise was a national rate. The promise was not the kind of differential we have today, Mr. Chairman. I thank you very much. You've got some great minds on this subcommittee who I know will be able to consider these problems and solve them most hastily.

[The statement of Mr. Dorgan follows:]

TESTIMONY OF
THE HONORABLE BYRON L. DORGAN
BEFORE THE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
MARCH 1, 1989

Mr. Chairman and distinguished Members of the Health Subcommittee, it my pleasure to address you today on a subject that effects the quality of life for millions of Americans: the Medicare budget. The significance of this program is awesome in its impact on the quality of life to its beneficiaries and on the fiscal health of our nation's health care delivery system. The decisions made by this Committee in relation to the Medicare program are felt directly not only by those who receive Medicare benefits for their health care insurance and but also by those who provide health care to Medicare patients.

In light of Medicare's significance and impact on so many individual lives, institutions, and communities, it is indeed disturbing that the President's fiscal year 1990 budget proposes $5 BILLION in reductions. Reductions of this magnitude will without a doubt result in limited access and shortcomings in quality of care for millions of our nation's elderly who rely upon Medicare for their health insurance. The President proposes reductions in Medicare's payments to hospitals and physicians. The annual update for hospital payments are targeted by the President for ways to save the program money. It is interesting to note that within the President's budget, the largest single reduction in entitlements would be in the Medicare program.

Mr. Chairman, I fear the kind of impact substantial cuts in Medicare's payments to hospitals will have on many facilities and communities. The inadequacy of Medicare payments over the past few years has placed many hospitals in fiscal vulnerability. Annual updates for Medicare payments to hospitals have fallen substantially below the rate of marketbasket increases. During the fiscal years 1984-1989, annual updates totaled 14.9 percent. However, the hospital marketbasket increased 28 percent. The President's proposal to limit the update to 1.5 below the marketbasket will continue to add to the disparity that many hospitals are experiencing in Medicare shortfalls.

In North Dakota, 51 percent of the hospitals reflected net losses from patient revenues in 1987. For the first nine months of 1988, 62 percent of North Dakota's hospitals reflected costs in excess of their patient revenues. The shortfall in Medicare payments is a major contributor to these loses. In 1987, Medicare shortfalls resulted in $50 million discounts in North Dakota. For the last seven years the discounts have nearly tripled.

MEDICARE LOSSES AND RURAL HOSPITALS

Rural hospitals in particular are critically more vulnerable to reductions in Medicare payments to hospitals. Since rural hospitals are typically more dependent upon Medicare patients for their admissions, alterations in Medicare payments effect them to a much greater degree than the larger urban hospitals. Although the elderly comprise 12 percent of the nation's population, 25 percent of the population in rural areas is elderly. Admissions to rural hospitals are likely to be as much as 70 percent Medicare patients. This makes rural hospitals more dependent upon Medicare payments for their survival. Since the elderly are less likely to seek health care outside their communities, many rural hospitals are likely to be the primary or even the sole source of health care for many Medicare beneficiaries. In North Dakota it is not uncommon that in rural hospitals over 70 percent of their inpatient days are Medicare days. This compares to 40 percent inpatient days at urban hospitals in North Dakota.

Rural hospitals are losing money at alarming rates. Compared to urban hospitals, a higher percentage of rural hospitals experienced losses on patient care (63 percent vs. 44 percent) in 1986. According to a recent Prospective Payment Assessment Commission (ProPAC) analysis, over half of the rural hospitals in the nation are losing money treating Medicare patients. In the first three years of the Prospective Payment System (PPS), 83 percent of the hospitals which lost money were located in rural areas. Currently, rural hospitals have the lowest Medicare operating margins of all hospitals. In fiscal year 1989, 15 percent of North Dakota's hospitals are predicted to have negative operating margins of nineteen percent or more. That means that Medicare will pay 80 cents on the dollar to one out of every four of North Dakota's hospitals.

CRISIS IN RURAL HEALTH CARE

In light of these loses, it is little surprise that last year 43 rural hospitals closed across the United States. In the previous year, 40 hospitals closed. Since 1980, 163 rural community hospitals have closed their doors and as many as 600 rural hospitals face the prospect of closure in the next five years.

These closures signal that rural America is facing an eminent health care crisis. This crisis is an issue of access to basic health care for many Americans, Medicare and non-Medicare patients alike. The closure of a rural community hospital can mean the loss of the sole health care facility for a community. If these closures continue, many rural communities will be several miles away from basic health care.

The rural health crisis is an issue of quality of care. When a rural hospital closes its doors, patients can find themselves so far away from a physician and health care facility that routine health maintenance becomes extremely difficult and emergency care non-existent within a critical distance.

Rural hospital closures are an economic issue. In many rural communities, the hospital is generally the largest or at least one of the largest employers of the community. Not only does closure mean a loss of jobs, but the rural community's prospects for future economic development are inextricably linked with the maintenance of a viable health care delivery system. The economic health of a rural community in many cases depends on the fiscal viability of its hospital.

INEQUITIES IN MEDICARE REIMBURSEMENT:
THE URBAN/RURAL DIFFERENTIAL

Rural America is looking toward the members of this Committee for leadership and guidance for the salvation of rural health care delivery. The slightest alteration in Medicare reimbursement policy will dramatically impact the present viability and future existence of the rural health care delivery system. The decisions made by the Members of this Committee will decide the fate of many rural hospitals.

There are a number of inequities in the current Medicare reimbursement policy that demand immediate attention by this Committee if rural health care is to be saved. In many respects, Medicare's reimbursement policies have contributed to the eroding financial viability of rural hospitals.

First, the current differential in Medicare reimbursements is approximately 11 percent less to rural hospitals in the basic rate of payment to hospitals. With all of the adjustments measured in Medicare payments to rural hospitals, namely the wage index, the differential is actually about 40 percent lower than what Medicare pays urban hospitals. A recent comparison of Medicare's payment of top DRGs showed that a rural hospital in North Dakota received over $1,000 less for a treatment of a heart failure patient than an urban hospital 60 miles away.

At a minimum, Congress must eliminate this differential. This is simply a matter of equity. The differential has placed rural hospitals in an unfair disadvantage. I feel that the current policy has turned the logic of PPS upside down by placing the burden of proof on rural hospitals to make their case for the elimination of the differential. According to the philosophy of PPS, differences in payments should reflect costs that are beyond the control of hospital management. The technology-intensive practice of medicine in urban areas is largely unquestioned as being reflected in payment formulas. However, costs that rural hospitals incur, such as high overhead costs per patient because of lower admission rates, are not reflected in reimbursement formulas. My point is that many rural hospitals suffer additional costs which are clearly beyond their control and these costs are not given consideration under current reimbursement policy.

In light of the facts about the lower operating margins of the majority of rural hospitals, Congress must examine the so called "cost differences" between urban and rural hospitals and determine the true origin of cost differences and re-evaluate the fairness of how the costs are reflected in the payment formula. Current policy has imposed an arbitrary geographical classification system as a basis of different payments to hospitals. I have serious concerns about a policy that, its payment formula, systematically discriminates against a group of hospitals as a class.

The current differential in Medicare payments to rural hospitals needs to be eliminated. Rather than base payment differences on geographic classification, payments ought to be adjusted as to reflect true cost differences. I believe that it is time that a single national rate was established for Medicare payments to hospitals. This national rate should be adjusted to reflect the true differences by adjusting for severity of illness, utilization, and labor costs.

Equity in Medicare payments to hospitals will have a tremendous impact for rural hospitals without dramatically impacting the Medicare program. If the solution were to come in the form of raising the rural payment rate to that of the urban payment rate, then the cost would be an estimated $40-60 million. Alternatively, the payment rate for urban and rural hospitals could be equalized without effecting total PPS outlays by increasing the rural rate and decreasing the urban rate. ProPAC estimates that the equalization of the standardized rates would raise the rural standardized amount by 11.5 percent while the urban rate would decrease by only 1.6 percent.

ASSURING ACCESS TO HEALTH CARE IN RURAL AREAS

The elimination of the urban/rural differential is by no means the single answer to addressing the current crisis in rural health care delivery. Rather, it is only a start in establishing equity in Medicare patients. In order to guarantee access to adequate health care for our nation's Medicare beneficiaries, Congress must act quickly to ensure that some critical access facilities remain open to provide health care.

I certainly am not one to suggest that it is the role of the Medicare trust fund to guarantee the financial solvency of hospitals in general. But I think it can be argued that the Medicare program has established a commitment to its beneficiaries to ensure access to health care. Therefore, Medicare has an obligation to ensure that critical facilities remain open to serve Medicare patients. As the Senate Special Committee on Aging report on Rural Health Care concluded: "the dire financial straits in which a number of small rural hospitals find themselves raise several serious public policy concerns."

For the most part, PPS is not working for small rural hospitals. When these hospitals are typically the sole source of health care for a miles around, Congress must take a look at what adjustments can be made to help these critical hospitals. PPS is a system based on the presumption of large numbers of high patient volumes. For small rural hospitals with low patient volume, such a system does not work.

Proposals to remove a certain class of hospitals, like small rural hospitals, off of PPS run the risk of opening the door for every special interest to ask to be exempt from the system. This approach has dangers which I would like to see avoided. Rather, I think that some immediate adjustments can be made that will not challenge the underlying philosophy of PPS and yet provide the necessary assistance to those small rural hospitals that are on the verge of closing their doors.

I think that the Committee should consider providing additional payments to small rural hospitals that make up for the Medicare shortfalls in the PPS payments. When Congress adopted provisions to protect sole community providers, it recognized the appropriateness of using Medicare funds to assure access to medical care for Medicare beneficiaries living in remote or underserved areas. In many rural areas, preservation of the hospital and preservation of access to health care are virtually indistinguishable.

Since many small rural hospitals are struggling for survival, perhaps the solution is to provide an additional payment to protect small rural hospitals as a class on an interim basis until single national rate is established. Once equity is established and a single national rate is fully in effect, then this additional protection will be provided only to those hospitals which are identified as critical access facilities. Under this proposal, Medicare would only be protecting those hospitals that truly must remain open because of their critical location and service to Medicare beneficiaries.

OTHER ADJUSTMENTS TO MEDICARE REIMBURSEMENTS TO HOSPITALS

Current protections intended for sole community providers appear to be ineffective. The fact that Medicare has failed to provide adequate financial support for sole community providers is evidenced in the reality that many hospitals that meet the criterion for sole community hospital status do not even apply. It is certainly very telling when 119 hospitals eligible for this program have never been designated. Also, many designated sole community hospitals are leaving the program. North Dakota currently has eleven sole community hospitals and this number is declining every year. Congress needs to re-evaluate the calculations in the payment formula, simplify the application process and reassess the eligibility criteria, and address the problems with the requirements in the application for the volume adjustment protections. (In one case in North Dakota, a hospital had to apply three times before it received a favorable decision for the volume adjustment protection. This process took 23 months!).

Rural hospitals are particularly vulnerable to loses incurred by outlier cases. Since rural hospitals do not have the high patient volumes to spread out losses, the hospital discounts very high costs in treating Medicare patients requiring expensive treatments and utilizing extended stays in the hospital. One example from a hospital in Rugby, North Dakota is very telling. This hospital received an average of $35.71 a day for treating a Medicare patient who was in for 82 days because of complications. The hospital's costs for treating that patient was nearly 8 times the daily reimbursement. The hospital had to discount $111,523 on this patient alone.

One of the most immediate problems rural hospitals are faced with is shortages in professional staff. The nationwide nursing shortage and the difficulty in attracting physicians to rural areas poses a serious threat to not only the quality of care patients are receiving but also to the ability of the hospital to remain open. Changes in the Medicare Area Wage Index can have a significant impact in addressing the professional shortages that many rural hospitals are now facing.

The labor portion of the standardized PPS payment is approximately 75 percent. Thus, an inappropriately low wage index has a major impact on each PPS payment. The problem with the wage index for rural hospitals is that all rural hospitals in a state have the same wage index, while urban hospitals receive a wage index specific to their area. This policy makes the incorrect assumption that the rural hospital labor market is merely a local one. The fact is that rural hospitals face multiple labor markets. The current wage index for rural areas fails to account for necessary distinctions between professional and non-professional personnel. Rural hospitals may draw non-professional staff from the local labor market but they still have to compete with urban hospitals for their professional staff. Inadequate Medicare payments in relation to the wage index have only exacerbated the existing difficulties in competing with urban hospitals to recruit physicians, nurses, and other professional staff. Rural hospitals cannot compete with urban hospitals in offering financial incentives to attract physicians, nurses, and other health professionals. It is urgent that the Committee examine the negative impact the current differential in the wage index has on the professional shortages in rural areas.

THE FUTURE OF RURAL HEALTH CARE

The adjustments in Medicare payments to rural hospitals that I have outlined above alone will not ensure the viability of rural hospitals. I do not feel that the solution to the crisis in rural health care is simply a matter of channeling more funds to rural health care facilities. The adjustments that I have mentioned are adjustments to restore equity in Medicare's payments to hospitals.

However, there is much more that can be done to assist rural hospitals transform into medical facilities for the 1990's and beyond. The Committee must begin examining ways in which Medicare payments can be structured in order to promote responsible strategic planning and the transformation of facilities to adapt to their environments. The swing bed program is but one example of how Medicare can assist in the transformation of facilities to provide efficient care to Medicare beneficiaries.

Rural hospitals face declining utilization of inpatient services, declining revenues, and increased competition for patients and staff. In light of these trends, coupled with the demographic transition of declining populations in rural areas, rural communities must coordinate their services and transform their facilities. The essential concern is that adequate health care is provided for rural communities. However, this does not necessarily mean that that care must be provided by hospitals as we know them today. It is up to the health care industry, rural communities, and policy makers to develop proposals on what transformations need to be made.

In my judgement, Medicare can provide incentives, as well as remove some current structural disincentives, in its payments to hospitals that can help rural health care delivery meet the challenges of tomorrow. I encourage this Committee to work with the health care industry and policy experts to examine ways to facilitate necessary changes for the future of rural health care delivery.

Chairman **Stark**. I thank the gentleman and I will just ask you one question because I am not sure that I understand the problem. I am not sure the solution you suggest will save the hospitals and I urge you to talk to the hospitals in North Dakota. Even if they had the rate of the urban hospitals, I am not sure that they wouldn't still be in financial trouble.

I am perfectly willing to work with the gentleman, but if we're going to bite the bullet, as it were, and find a solution, I'd be more inclined to find one that's going to keep these hospitals open. And I think their problem is going to be volume, which may be combining or sharing facilities, which I suspect we could facilitate.

I just don't think the 2 or 3 or 4 or 5 percent increase per procedure is going to bail them out. And I would like to work with the gentleman on specific cases, because I think we could find something that would help solve his problem. I'm just not sure that it is a simple minor increase. And I——

Mr. **Dorgan**. Mr. Chairman, I might say that volume is not a new issue. Volume was an issue in the 1950's for small hospitals. If we decided that health care facilities and the long-term presence of those facilities in rural areas is a function of volume, then we condemn a whole lot of rural areas to a life without hospitals.

My point is that we certainly preordained much greater financial stress for rural hospitals by giving them a much lower rate——

Chairman **Stark**. No, I am suggesting that there may be other ways to help them. I am not suggesting for a moment that we have to go with a meat ax and close every 4 out of 5. I am just saying that we may have to reimburse them differently.

Mr. **Dorgan**. I understand that, except that my point is that there is a certain way to injure rural hospitals, and that's to do what we've done. That's to say to those smaller hospitals, because you are smaller, because you are in a rural area, because you have less volume, you get less money per case, per procedure, than your neighbor 40 miles down the road. That's a certain way to inflict financial injury and that's precisely what we've done.

Chairman **Stark**. Thank you, Gentleman. Mr. Gradison.

Mr. **Gradison**. I have no questions.

Chairman **Stark**. Mr. Coyne.

Mr. **Coyne**. Byron, I was interested in your endorsement of Congressman Pickle's idea to do away with the differential. He also said that he would do away with the differential if the cost of rural hospitals were equal to the cost of urban operations. Do you think that that's a valid observation on his part?

Mr. **Dorgan**. Oh, sure, I have met with our hospitals in North Dakota at great length. I have had meetings with all our hospital administrators since the first of the year. I don't think that there is any question that they have in many areas higher marginal costs because they are rural hospitals.

I think Bob Michel put it well. If they are going to buy a piece of equipment, do you think they get it cheaper than a urban hospital. Of course not, they buy it from the same place. A substantial amount of what rural hospitals must spend is at a cost that is equal to or greater than other hospitals.

The only area is in labor. Incidentally, many rural hospitals these days in all areas are competing with almost everybody else within 100 miles for nurses, who are in shortage, and other skilled professionals.

Mr. COYNE. But I think the question is: would you support eliminating the differential, whether the costs are the same or not, after study and review of the question?

Mr. DORGAN. The elimination of the differential with respect to the national rate is a promise. I mean, that's not a negotiable thing at this point. The only reason that we are negotiating is because we haven't had the votes to trigger the promise. So, that's a commitment that's been made. Now, the question is when does it get fulfilled. I'm sure that we will find a basis, perhaps, for wage adjustments in certain areas under any scheme. But I think that you will not find anything that justifies a penalty rate for rural hospitals of the type that they've been assigned these days.

Chairman STARK. Thank you. Mr. Crane.

Mr. CRANE. Thank you, Mr. Chairman. Byron, just one question on the cost differentials. Roughly, do you know how many hospitals you have in the State of North Dakota?

Mr. DORGAN. I don't know it off hand, but I believe it's 50 hospitals, roughly.

Mr. CRANE. Do you know how many of those, for example, have or are equipped with a CAT scanner?

Mr. DORGAN. No, I don't know the answer to that. I can find that quickly.

Mr. CRANE. Well, the only reason that I asked that is there's a lot of sophisticated and very expensive equipment, and high volume hospitals in dense population areas have absorbed those costs. But I am not sure that those are costs that realistically a hospital that Bob Michel was describing, you know, with 40 beds and 17 of them occupied, can absorb. Concerning labor, I agree with you. I think that in many respects, given the shortage of nurses today, you might have to provide an enticement to get a nurse to go out into a rural area. But another big component of hospital cost is equipment. And while it cost the same one and all, not all hospitals have absorbed the cost of some of that sophisticated equipment, and I just throw that out, because I would like to see it factored into making the kind of determination as to what we can afford and what we can't.

Mr. DORGAN. Well, I think it is factored in and you don't buy a CAT scanner in my State, or perhaps in yours, unless you meet a certificate of need requirement by a State health office. At least in our State, that's the case. I might say that the fact that there is more sophisticated equipment in urban hospitals, again, preordains that you will have fewer patients in rural hospitals.

That is one of the things that contributes to a lower population of hospital days used in rural hospitals. I understand that, but I think that if you take a look at the rate versus the cost, you will discover that if you were the administrator of a rural hospital, what is going on today in reimbursement is not supportable.

Mr. CRANE. Good enough. Thank you, Byron.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. I want to thank the gentleman from North Dakota for his leadership in this field. He is working with the Rural Health Care Coalition and they're trying to find an answer and to introduce legislation on it. Some of us have done the same thing because we recognize this as a problem. I repeat to you again, we've got to come up with facts to show that the cost of rural hospitals are indeed as high as the urban operation. And if we can show that, I don't see why we'd have any justification for giving them a different rate or lower rate. It ought to be closed right here.

But then again, I got to say to those rural residents, they've got to use rural hospitals. The only question I would ask you is, you apparently said that even if you established a national rate, and the inequity was closed, that some rural hospitals would still need additional payments. Can you justify that? That would kind of be a subsidization over and above the national rate. Is that what you have in mind? Or can you comment on that?

Mr. DORGAN. I certainly think that we ought to discuss that. I think the policy we've developed determines where hospitals will exist in this country's future. I think if there is a class of hospitals that because of their remote nature, because of their extraordinary costs, would require cost reimbursement with some protections in certain areas, I would support looking at that.

Mr. CRANE. I don't know that we can go beyond the national rate, but we certainly ought to get to the national rate. However we arrive at it is the problem of this committee. I do appreciate the leadership you've given in this field, and we thank you.

Chairman STARK. Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman. I would like to also thank my colleague for his articulate way of presenting the arguments and the forceful way in which he is willing to stand up for his principles, and I agree that it is time that we say, a promise made is time for a promise to be kept.

We don't have the votes, but I do believe that after the difficult legislative battles that we've gone through the last few years that I think some of our urban colleagues recognize that we are in trouble and I think their attitudes are slightly better than they were in the past, if we can find a way to solve the problem.

Mr. Chairman, I would just encourage you not to use the word bailout. I think with the savings and loan situation, that bailout now has a very negative connotation in terms of whose fault it is and personally I think access, equity, and keeping promises is more in line with what the real promise is. I personally do not feel like I'm representing my real constituents in coming to this Congress and asking for a bailout. So, I just ask you if you would—to try to find a different phrase to categorize what our——

Chairman STARK. The gentleman's point is well taken in respect to the paratroopers——[Laughter.]

And the savings and loans. Your point, I think is well taken. I will think of another term.

Mr. ANTHONY. And I just close by saying, I think you've stated the whole public policy, Byron, in one sentence in your statement. You said, I have serious concerns about a policy that its' payment formula systematically discriminates a group of hospitals as a class. And that sums up the whole problem and we ought to solve it. And I thank you for your leadership in this area. I look forward to working with you toward a solution. Thank you.

Chairman STARK. Mrs. Johnson.

Mrs. Johnson. I appreciate your testimony today and wonder if in your conversations with your hospitals you were able to get from them any sense of what it is specifically that's driving their costs. I ask this question because one of the problems in our system is that the most concrete data is usually 2 years old and the more recent data is a compilation, at least it's my understanding, of some data that we know and some that we guess at.

Have your hospitals talked to you about the difference between their costs 2 years ago and their costs now? And, in other words, how much of this problem is just efficiency? How much do they have control over? How much do they not have control over? When I do what you did, sit down with your hospitals, I come to the conclusion that they don't have a lot of control over some of the things that are driving costs, that cannot be seen from Washington because they're more recent than 2 years old. And I just wondered what was your evaluation, in sitting down with these hospitals, of the cost drivers?

Mr. Dorgan. Well, let me go back to the issue of the law of large numbers. I think that it is very difficult to measure the efficiency of rural hospitals as you would measure the efficiency of a 500-bed hospital. The whole purpose of prospective payment was to understand there's a certain level of reimbursement that's appropriate for certain diagnoses. If your costs are above that, it means you are probably not very efficient. Because on the average, you ought to be able to provide care for that particular diagnosis at this level of cost. If you are very efficient, you will probably experience less cost than that and therefore make some profit. Because you have hospitals with 16 patients on average throughout the year coming in and out, it is very difficult to determine where is the efficiency here.

But I can tell you this, again, if we were the administrators of those hospitals and the diagnosis was the same at our hospital for that elderly patient and 70 percent of them was elderly, whereas our neighbor hospital 60 miles away had a 40 percent Medicare patient load, when that patient comes in and the diagnosis represents X, we get 25 percent less money than the hospital 50 miles away. That's a very serious problem for them.

Mrs. Johnson. I agree that there are real problems with the rural rate. I agree with that. I think you made your point that access is worth something. That occupancy rates alone can't determine whether that hospital ought to exist, and that access to care is of value in and of itself—and something that we ought to consider how much we are willing to pay for are both legitimate points.

But, it would be interesting if you'd go back to your hospital administrators and ask them questions about how they do their budgeting. I had one of my administrators sit down and go through with me what costs he was able to predict at the time he made his budget only 1 year ago. I come from a highly regulated State where we oversee hospital submissions on an annual basis. He was able to sit down and say these are the assumptions on which I made my budget which were all valid 1 year ago.

Since that time, we have had a crisis in nursing salaries, the new directives in regard to aids prevention came down, and he had to go to a higher grade plastic—it may sound like a little thing, but it was worth more than $300,000 to him.

The Federal Government has started paying him 6 months late. He's had to borrow $3 million to cover his costs. So he's got interest payments.

I think we need to know what are the concrete things that are feeding into their costs this year, as opposed to last year. Because one of our problems in dealing with this whole subject matter area is to try to find some way that we can give ourselves a more updated, factual basis from which to start.

So any further information you can get from them on those matters would be of interest to me.

Mr. DORGAN. That's a very good point, and I suppose, for example, the delay in Medicare payments to hospitals affects urban as well as rural. That's another gimmicky way to show a reduction in the deficit while you impose the cost on someone else.

There's a whole range of things that we probably need more information on. I don't disagree with you on that.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Mr. Chairman, I don't have any questions, just a comment.

I think the testimony this morning already has shown that this is really not them against us. For example, there are lots of similarities in the problems facing intercity hospitals as rural hospitals.

They're not identical sets of problems, but they're rather similar.

Thanks very much.

Chairman STARK. Mr. Chandler—Mr. Donnelly.

Mr. DONNELLY. Thank you Mr. Chairman. Byron, thanks for coming.

I feel somewhat johnny-on-the-spot here with our first two witnesses. Every time urban is mentioned I'm either looked at or the State of Massachusetts is mentioned.

But let me just say that I agree the present system is not working as it should. Not just in regard to the differential. I think as we look at the entire system, maybe it ought to be time to revisit it.

Now, let me ask you this: have any hospitals in North Dakota closed since PPS was adopted?

Mr. DORGAN. We've had North Dakota hospital closures. I don't know whether it's been since 1983, or since 1984 of the implementation. I can get you that information.

But let me just tell you. We've got literally a good number of hospitals in small communities teetering on the edge of closures.

They don't know where to go or what to do because of their extraordinary high population of Medicare patients. I would guess, you know, in most Massachusetts cities, the patients coming through the door would represent much, much less than 70 percent Medicare patients.

And that's where you get into the problem.

In North Dakota it's 70 percent of your patients.

And so, when you lose on Medicare patients, if you lose, you've got to charge a higher fee to the private pay patients some place. You've got to transfer that lost to some place.

If you have 70 percent Medicare and 30 percent private pay, you don't have any population out there to transfer to.

That's one of the problems.

Mr. DONNELLY. I also noted your final statement in your prepared remark that the rural members intend to lobby harder and work harder and play tougher in this session of Congress.

I suspect my life will be somewhat miserable over the next few months.

But I think all of us from urban areas would agree that the present system is not working as it should.

And I think we can start from that basis. The question is how do you divvy up that shrinking pie that's getting smaller and smaller, and smaller.

And as we look out to the future, Byron, it's going to continue to get smaller—maybe we have to go right back to the beginning and revisit the whole mission of Medicare, and whether we ought to be in the business of funding hospital expansion and hospital renovation.

We also need to determine whether we ought to be in the business of training and paying the training of physicians and nurses, and whether we ought not just be in the business of taking care of our beneficiaries.

I think the mission of Medicare in 1965 is much different than the mission of Medicare in 1989.

And, maybe those are the types of issues we can discuss as we negotiate and try to deal with what I think presently is an unfair system.

And, I look forward to you—spending the process in working with those of us from both urban and in rural areas.

Mr. DORGAN. Mr. Donnelly, then your trip to North Dakota some years ago would have been very beneficial to understand what a rural area truly is.

I maybe should amend my opening statement and make a different analysis.

North Dakota is not just 10 times the size of Massachusetts. It's 10 times the size of El Salvador. We could substitute that to increase your comfort level.

Mr. DONNELLY. I don't know the relationship between El Salvador and Massachusetts. I'll let that pass.

Mr. DORGAN. Mr. Chairman, thank you very much for offering me the opportunity to testify.

Chairman STARK. Thank you very much for participating.

Our next witness is the distinguished Chairman, Dr. Stuart Altman, of the Prospective Payment Assessment Commission, affectionately known as ProPAC. Stuart, it's good to have you back and without objection, this morning, your prepared testimony will appear in the record in its entirety. You may proceed to expand on it, amend it, or enlighten us in any way that you choose.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION [PROPAC], ACCOMPANIED BY KATHRYN M. MERSHON, R.N., AND DONALD A. YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. ALTMAN. Thank you Mr. Chairman. First, I'd like to introduce two others with me.

On my right is Kathy Mershon who is a Commission member, a registered nurse, and a hospital administrator working for the Humana System.

And on my left is Dr. Donald Young, the executive director of our staff.

As you indicated, I do have written testimony which I would like to put in the record. To those in the audience, we have given them a test. In addition to showing how complicated the PPS system is, we now find our xerox machine almost as complicated.

And so, the audience may find their testimony a little difficult to follow because the pages don't follow in order, and I apologize.

But for those of them who didn't know it when they read it, it indicates——[Laughter.]

I would like to just briefly summarize, and I appreciate the discussion that has gone on this morning and much of it supports our analysis. We do have some different information that might also bear on this discussion.

We are very pleased this morning to present you with our fifth annual report, which was delivered to you this morning and includes our recommendations in detail.

As we indicate in the report, the PPS system replaced more than 16 years of a cost-based reimbursement system. And while there have been a number of issues raised this morning, for the most part the system has worked well in terms of allocating dollars.

We are not talking about the size of the pie, but rather its allocation system. Nevertheless, serious problems do remain and you talked about some of them this morning. And others I'm sure will come up in our testimony, and I will bring several of them up as we go through the discussion.

ProPAC, as you know, is made up of 17 independent commissioners, 4 of whom are hospital administrators, 5 of whom are physicians, several are economists, and others work for insurance companies and the like.

Since the beginning of our deliberations 5 years ago, we have tried to present you with our estimates, which we believe are both fair to the hospital system, but which recognize the tough financial situation that our Medicare program and our country are in.

However, I want to emphasize Mr. Chairman, our recommendations today, as in the past, were not guided by an attempt to reduce the deficit. We've tried to give you our best shot in terms of what we believe would be an increase which would maintain high quality and access to care, and yet maintain fiscal constraints that everyone believes are necessary, in order to keep moderate growth in our $40 plus billion part A hospital Medicare program.

As a matter of fact, when you look back at our PPS recommendations, we have recommended between 1.5 and 2.6 percent less than the estimated marketbasket increase each year, and this was recommended unanimously every year.

Because for the most part our commissioners have tried to look at the information, even though at times that information was a little painful for commissioners' individual hospitals. I can say without any qualifications that these individual commissioners tried to do the best by the system, not for their own individual self-interest.

For the most part, factual information has driven our recommendations, although there are times when judgment must prevail, and that's why you put the Commission together.

And I think this year, more than any, judgment is very important.

As I indicated in the closing part of my testimony, in a very real sense, PPS starts October 1, 1989.

We've had a roller coaster over the last 5 years. We've significantly overshot the mark during the first 3 years of PPS, generating profit margins around 15 percent for the first years; 9 percent for the third year.

Then we sort of went into a dip where the margins dropped precipitously 4.50, and our estimates are that more than 50 percent of hospitals in this country, this year and next will lose money on Medicare and many of them will lose money regardless of how they count.

My own view personally is that this roller coaster does need to stop. It's very difficult for any industry to plan ahead with this kind of up and down.

So in a very real sense, we all face a new beginning this year to develop a set of estimates and a rationale that would allow this industry to plan ahead, recognizing that they won't have all the money they want but there will be adequate reimbursement for those that can live within limits.

I do want to emphasize something that does get lost—because we keep talking about revenue shortfalls.

The other thing you have to recognize is that costs per admission, costs per hospital case have been growing in excess of 10 percent a year for 3 to 4 years in a row, and these increases are very sizably above increases in other sectors of our economy, as well as above overall inflation.

The other thing that needs to be borne in mind is that it is not correct to only look at the update factor.

Hospitals have received more money through other adjustments then they have through the update factor, but we tend to focus on the update factor.

Our estimates indicate that hospitals, through case mix index adjustments, receive money in excess of what would be required for treating sicker patients.

And that's why in our calculations we look at total revenues, not only the update factor.

The third troubling statistic is the amount of variation that exists in our system. The averages do mask a lot of variation, and even in this very tough period, there are hospitals making more than 30 percent margins on their Medicare patients.

And as I point out in my testimony, we are very close to the point of deciding whether we want to protect individual hospitals, or groups of hospitals, against low margins.

And if we decide to do that—if you decide to do that—we have crossed the line between a payment system that establishes a rate and lets hospitals compete and move into a regulatory environment.

Now, honest people could differ on that issue. But I will tell you this Mr. Chairman, if we pass that line, a whole set of calculations need to come into play.

And that is we then have to go line by line and ask, invariably—are those costs justified? What is appropriate profit margin?

We have not crossed that line yet, but as you single out classes of hospitals and say, "their profit margins are too low, we need to prop them up," it is just the beginning.

The Congress has already done that and the Commission supported it. You've decided large urban hospitals were not receiving high enough payments, and you singled them out.

We have singled out rural hospitals. We've made substantial progress in giving them additional payment. These changes were justified.

But ultimately, as I said before, we are very close to that line and I think it's going to need a lot more discussion.

And I would add, should you want more discussion on that, we at ProPAC would be glad to look into it.

Understand what I am saying. I am not recommending it. As a matter of fact, if you push me, I would recommend against it. But we are very close.

Now let me, if you don't mind, go through briefly our recommendations.

Chairman STARK. Stuart, back up just a little bit. What would you recommend against? I want to make sure——

Mr. ALTMAN. I would not recommend going to a full regulatory system where we essentially decide for each class of hospitals there would be a profit margin which would be acceptable and we would define revenues to shoot and then start regulating cost by cost—you know, the public utility model.

I think in spite of all the criticisms, in spite of all the problems, the PPS system is a better system.

Mrs. JOHNSON. Mr. Chairman, would you yield?

I understand you to say you would recommend against going to such a system.

Mr. ALTMAN. Yes.

Mrs. JOHNSON. Okay, thank you.

Mr. ALTMAN. Mr. Chairman, the Commission recommends an average increase in the level of PPS prices for 1990 of 4.9 percent or about 0.8 percentage point below the projected market basket level of inflation.

This average would consist of an increase of 5 percent for hospitals in large urban areas, 4.5 percent for hospitals in other urban areas, and 5.6 percent for rural hospitals.

As I indicated in my testimony, and I will reiterate, we do believe rural hospitals should be receiving additional payments to makeup for shortfalls in the past.

And we have recommended this for 3 years running, and we believe over time these extra payments will bring a fairer linkage between their costs and their revenues.

In my testimony I go through how we've come up with these calculations and I won't go through these now unless you're interested.

But I do want to mention again that we have recommended a higher update for large urban hospitals, which is consistent with what your committee recommended.

This is because we've found, for the most part, these higher urban areas do have costs which are higher, and unaccounted for by the payments, than smaller urban areas. Therefore, we have added a 0.5 percent higher rate for them.

As in the past, we have made recommendations for the excluded hospitals which are much closer to the market basket because of the inability of these hospitals to get extra payments through case mix adjustment.

I now want to focus on a very complicated and clearly controversial issue, and that is the indirect medical education adjustment.

As you know well Mr. Chairman, when the system was put into place, there was concern that our largest, most prestigious teaching hospitals would serve sicker patients, patients who were not adequately covered under the new system, and an extra adjustment was put into the system.

Everybody recognize very quickly that the adjustment overshot the mark. And we have been constantly adjusting it down.

First from a factor of 11.5 to 8.1, and now we are at 7.7. We use a rather complicated regression model to calculate this.

Every independent estimate in this town and around the country that uses that model suggests that the adjustment is too high.

If you just use that model, it indicates that rather than being 7.7, it should be closer to 4.4. The President and the previous President recommended that it should be closer to 4.

In the President's budget they've recommended immediately dropping from 7.7 to 4 percent. That would be a reduction in that teaching adjustment of almost 50 percent. That amounts to more than a billion dollars, taken away from 150 to 200 hospitals.

While our numbers are similar, the Commission believes that the President's budget proposal is (*a*) much too precipitous a drop, and (*b*) if you take a bigger picture, and I think it's important to emphasize this, the Medicare program is not in isolation. We think you need to look at not only Medicare payments, but total payments.

And when you look at total margins, our largest teaching hospitals, when you look beyond Medicare, rather than being the most favored flip around, and their margins become lower than other hospitals.

And therefore Mr. Chairman we have recommended a modest reduction in the teaching adjustment from 7.7 to 6.6, and we recommend that the money that's taken from the teaching hospitals be put back into the pie from which it came and redistributed to all hospitals. In this way, the teaching hospitals would get back some of it, but not through the teaching adjustment.

We do this more to level the playing field, not as a budget deficit reduction item.

Of course, if you choose to use it differently, it could impact dramatically on the budget.

We recognize that this is a very complicated area. This formula is very complicated. We don't completely understand all of what we are doing.

And therefore I have instructed our staff and other Commissioners working with our staff to prepare a technical briefing for you—a report—which we hope to have available on this subject by late spring.

Because after all, what we are talking about is the financial viability, as I indicated, of our largest, and quite frankly, most prestigious hospitals all over the United States.

I hope that report, when it is completed, will be of help to you.

Let me now just summarize, first by indicating that we will be bringing before you in April a report that you have asked for on payment for ambulatory surgery procedures.

And I don't want to completely jump the gun, but we are going to recommend to you a prospective payment approach for the facility component of hospital outpatient surgery.

And I want to emphasize one other thing. The existing system for outpatient surgery payment has tended to be very unfair to the Medicare beneficiaries.

There are Medicare beneficiaries who go to outpatient surgery units in hospitals who could wind up paying 40 or 50 percent of the cost that the Government pays.

Clearly a rate that's far in excess of what is intended in the law. Now, what is technically correct—it's not that its illegal—but it is an interpretation of the law that I find distorts the result.

And the system we recommend goes much closer, in fact goes right to what the law says, that Medicare beneficiaries pay the same 20 percent regardless of where they go to receive their care.

Again, we will talk about that in April. And I understand that we are going to be testifying before you.

In conclusion Mr. Chairman, the Commission believes that PPS, for the most part, has met many of the goals that were established for it.

The rate of growth of Medicare's inpatient expenditures has moderated. In recent years, however, as I indicated, hospital margins have fallen precipitously.

Partly because, as I indicated also, of large and unexpected cost increases. We have not found evidence of substantial changes in quality nor have we found evidence of major reductions in the diffusion of new medical technology.

On the other hand, we have witnessed an increasing number of hospital closures. ProPAC is currently studying this trend, and I have with me today some preliminary information on these hospital closures should you be interested. I will talk to you about that.

But I will indicate that even this preliminary information suggests that hospitals that have closed have tended to have fewer admissions, and have lower occupancy rates than other hospitals.

And interesting, about half of the hospitals that have closed have been in urban areas and about half in rural areas. To the extent hospitals are closing because they are underutilized, or have longstanding financial problems, closure may be appropriate, especially when there are other hospitals in the area.

However, as was indicated this morning, it is necessary to examine more closely to make sure that in those areas where hospitals close, that the beneficiaries have access in a reasonable period of time.

In some sense, as I indicated, we are really at the beginning of PPS. The first 5 years were needed to become accustomed to the system, to make some basic adjustments, and to correct initial areas.

Now we are in a position to observe the longer term impact of a more tightly controlled payment system for Medicare than has ever happened before.

We at ProPAC are anxious to help the Congress and the Secretary as we enter the second 5 years of PPS, and we will be pleased to continue to assist you in every way we can.

Thank you Mr. Chairman.

[The statement of Mr. Altman follows:]

Statement of Stuart H. Altman, Ph.D., Chairman, Prospective Payment Assessment Commission

Good Morning Mr. Chairman. I am pleased to testify before the subcommittee this morning and present the recommendations of the Prospective Payment Assessment Commission for updating and maintaining the Medicare Prospective Payment System for fiscal year 1990. Our fifth annual report to the Secretary of Health and Human Services containing these recommendations was printed over the weekend and I believe you have copies of it this morning. Additional copies will be available from ProPAC's offices for members of the press and the public at the end of the week.

These first five years of PPS have provided many challenges to hospitals and to the Medicare program, but there has been considerably less disruption than might have been expected. The system that replaced more than 16 years of cost-based reimbursement -- termed revolutionary only five years ago -- is now an established part of the U.S. health care financing structure. Nevertheless, several problems persist in the system, and further refinements are necessary. In addition, our information indicates that the hospital industry has not yet fully adjusted and adapted to the incentives of PPS. The Commission, however, believes that the program has met many of its important goals.

Background

Before I describe this year's recommendations, I would like to take a few minutes and make some general observations and describe some of the Commission's overriding concerns.

ProPAC decided during its first year that while budgetary pressures were critical, it was not the role of the Commission to explicitly address this concern in its deliberations. Rather, in all of its recommendations over the years, ProPAC has sought to provide Congress and the Secretary with judgments that reflect the mission given it by PL 98-21 (the Social Security Amendments of 1983). Thus, in developing its recommendations, the Commission takes into account the hospital market basket, hospital productivity, technologic and scientific advances and long-term cost-effectiveness in the delivery of hospital services.

We have tried each year to recommend a tough but appropriate update factor which will encourage hospitals to be more efficient in the delivery of high quality care. In fact, in each of the past 4 years our recommended update factor for PPS hospitals has been 1.5 to 2.6 percent less than the estimated market basket increase for that year. Therefore, while the Commission develops its recommendations with knowledge of the tight Federal budget, ProPAC does not specifically take the need to reduce the deficit into account. Recommendations from ProPAC represent the combined views of its Commissioners about the appropriate changes in the system that will support a Medicare hospital payment system capable of providing access to high-quality care at efficient levels of payment.

For the most part, we have tried to rely on factual information in arriving at our recommendations. Clearly, this is not possible all the time and judgments must be made. The complexity of the judgments that we must make and that you must make is compounded by the problems of getting good information. Even though there is actually more and better data today than in the early years of PPS, getting timely and accurate data on hospitals and patients is still a problem for effective policy-making.

The recent information that we have been able to analyze suggests that early PPS rates were too high, contributing to large Medicare margins (revenues in excess of costs) for many hospitals. Our analysis has indicated average margins in excess of 14 percent in the first and second years of PPS, and about 9 percent in the third year. Over the next two years, however, average margins for Medicare patients appear to have fallen to nearly zero. In fact, our latest estimates suggest that the average PPS margin will fall below zero during the sixth year under PPS unless hospitals can slow the rate of increase in per-case costs. (EXHIBIT 1 shows these overall PPS margins in a bar chart.)

These financial circumstances must be considered in light of three important factors. The first is extremely rapid increases in hospital costs per case since the first year of PPS. Second, PPS payments have grown faster than anticipated because hospitals receive increases in DRG payments reflecting their ever-rising case-mix indexes. That is, the higher case mix index results in higher payments outside of or beyond the update factor increase that is enacted by the Congress. These extra payments from case-mix change are higher than warranted for treating sicker patients. The third factor is the significant variation among hospitals with regard to their financial status and their margins.

Medicare inpatient operating costs per case rose about 10 percent per year for the second, third, and fourth years of PPS -- more than 6 percentage points per year above the PPS market basket. Interestingly enough, during the first year of PPS, cost per case increases were limited to about 2 percent -- more than 2.5 percentage points below the market basket. That is, hospitals did initially appear to respond to PPS incentives to limit the growth in costs. What we don't understand is why this trend changed and changed so dramatically. EXHIBIT 2 shows the cost and payment trends graphically. One possible reason for the cost increases is that the high margins hospitals experienced in the first year of PPS lessened incentives for cost containment. Hospitals may also have changed their strategy from reducing costs to expanding the services they provide to generate additional revenue. A recent ProPAC study indicated that hospitals did not cut back on the types of services they provide. Rather, for many the preferred strategy during the PPS years has been an expansion of the services they furnish.

The variation in hospital financial condition is likewise extremely troublesome. Preliminary data for the fourth year of PPS indicate that almost half of the hospitals incurred losses under PPS, while more than 10 percent had margins of 18 percent or more.

The existence of large variations in margins across types of hospitals resulted in adjustments in the PPS rates. For example, the Congress addressed some of the variation in hospital financial performance under PPS by granting higher update factors to rural hospitals and hospitals in large urban areas. Continuing refinements are likely to be considered as more information on variation in financial condition becomes available.

The question that needs to be asked, however, is at what point in this adjustment process would PPS move over the line and effectively become a regulatory system whereby certain profit margin levels would be targeted for groups of hospitals, and is such a change desirable. Clearly, this is a subject which this committee and the administration needs to devote considerable attention to in the months ahead. If you wish, ProPAC would be more than pleased to assist you in this effort.

Let me now turn to our specific recommendations for the fiscal year 1990 prospective payment system. We hope that our conclusions, along with the analysis and explanations that we provide with our recommendations, will make your deliberations easier and better informed.

Update Factor Recommendations

The Commission recommends an average increase in the level of PPS prices of 4.9 percent for fiscal year 1990, or about 0.8 percentage points below the projected market basket level of inflation. This average would consist of an increase of 5.0 percent for hospitals in large urban areas, 4.5 percent for hospitals in other urban areas, and 5.6 percent for rural hospitals. The table attached gives a full picture of our update factor recommendations (EXHIBIT 3).

As you see, the update factor recommendations combine several components. The largest is the PPS market basket. Last month, when we developed our recommendation, it was forecast to increase 5.7 percent in fiscal year 1990. Our recommendation also includes a positive adjustment, currently estimated at 0.6 percent, to correct for underestimates in the fiscal year 1989 market basket forecast. We have also recommended technical changes in the structure of the market basket. These technical changes give more weight to hospital industry wages than the market basket currently in effect. The changes thus address in some measure the costs hospitals are incurring in response to the shortage of nurses and other skilled personnel.

It is the Commission's opinion that any cost increase related to scientific and technological advancement should be offset by increases in hospital productivity. In other words, new and important technologies or procedures should be purchased by hospitals with money saved by encouraging improved productivity. Therefore, we recommended a net 0 percent adjustment for these factors.

A negative net adjustment is recommended for case-mix change. This -0.7 percent adjustment is to offset the estimated added revenues that hospitals are receiving this year because of an increase in their DRG case-mix indexes that was not related to treating sicker patients. As I have indicated, we are very concerned about case-mix index change. Over the course of PPS, it has been a more important source of PPS revenue increases than formal annual updates in payment rates.

Our recommendation also includes a -0.8 percent reduction to the standardized amounts for urban hospitals. This reduction is the final portion of a three-year phased lowering of the rates that was previously recommended by the Commission. It accounts in part for the difference between actual first year PPS costs and the payment rates for that year. No reduction is applied to the rural standardized amounts because the reduction ProPAC originally recommended for rural hospitals has already been incorporated into the payment rates.

Finally, we have recommended a higher fiscal year 1990 PPS update for urban hospitals in MSAs with more than 1 million people. We have found that PPS accounts for most, but not all of the differences in costs between hospitals in large urban areas and other urban areas. We believe that research should continue to help us understand why costs are higher in hospitals in large urban areas, and we will continue to review this area.

Excluded Hospital Update Factors

For hospitals and units excluded from PPS, we have recommended that the target rate of increase be determined separate from the PPS update factor. We believe that rehabilitation, psychiatric and long-term facilities' target rate of increase should be 6.2 percent for fiscal year 1990 based on current market basket estimates. This reflects the increase projected in these hospitals' market basket, including a correction factor for the fiscal year 1989 forecast error. We believe that the target rate of increase for children's hospitals should reflect the projected rate of increase for the PPS market basket, also corrected for forecast error, or 6.3 percent.

Other Adjustments to the Payment Formula

We have undertaken major studies of the indirect medical education adjustment and outlier payment policy. Analysis will continue in both of these important areas in the future.

For this year, ProPAC is proposing to lower the adjustment to the PPS payment formula for indirect medical education from 7.7 percent to 6.6 percent. We further recommend returning the savings to the standardized amounts for all hospitals, to make this change budget neutral.

Our analysis this year used third-year PPS Medicare Cost Report data to derive an empirical estimate of the relationship between teaching effort and Medicare cost per case. This study led to a teaching estimate of 4.4 percent. However, further analysis revealed that reduction of the medical education adjustment from the current level of 7.7 percent to 4.4 percent would have a dramatic effect on payments to major teaching hospitals. Concern about the overall impact of precipitously lowering payments to teaching hospitals led the Commission to recommend that for this year, only one-third of the total reduction implied by the current estimate of 4.4 percent be removed from the adjustment. Thus we have recommended a 6.6 percent adjustment for FY 1990.

Before proceeding with further reductions in the adjustment, the Commission believes that a careful reevaluation is necessary of the models, the analytical results, and the impact such changes have on the financial condition of teaching hospitals. The Commission will continue its work in this area. We will undertake a thorough analysis to examine the current and alternative methods for estimating the relationship between teaching effort and Medicare cost per case. We will also continue to assess the financial impact of lowering the medical education adjustment on teaching hospitals and hospitals that serve a high proportion of low income patients.

We are preparing a technical report which describes and evaluates the analytic models and findings related to our analyses. This report will also discuss further analysis relevant to the indirect medical education adjustment. The report will be available in the late spring.

Other Important Issues

As I noted, we are particularly concerned about data collection and management. We recommend several changes this year reflecting this priority. First, we strongly urge the Secretary to collect more current data on hospital wages and hours of employment, and to use these data to update the wage index for 1990. We believe that a permanent mechanism should be developed for obtaining accurate wage data, and that the index should be updated at least every other year. We continue to believe that the labor market areas, within which the wage index adjustments are applied, need to be refined.

We reiterate our belief that the Medicare Cost Report is a vital source of information, and we urge the Secretary to initiate developmental work that will facilitate further use of the cost report as a source of data for decision-making purposes.

We propose continued evaluation of DRG refinements that HCFA has underway in several research settings, including recent work from a contract with Yale University. We find preliminary results from this work positive, but believe that much remains to be done.

Because we are concerned about the impact of PPS and the PRO program on quality of care, we urge the Secretary to undertake a comprehensive synthesis, analysis and evaluation of the findings of PRO review activities. We likewise recommend that the Secretary continue a comprehensive research and policy agenda to address the financing and organizational issues of rural health care.

In response to congressional mandates, the Commission previews its upcoming April report on a prospective payment system for ambulatory surgical procedures. We recommend an entirely prospective payment for the facility component of hospital outpatient surgery. This payment should result, we believe, from a blend of current costs and rates, and be updated annually like PPS payments. We also recommend that the methodology used for calculating the Part B beneficiary coinsurance amount for hospital ambulatory surgery be restructured to assure that it is not greater than the 20 percent of the actual payment established by Medicare for that service. We will be testifying on this subject in detail before you in April, I believe.

Conclusion

At the end of five years, it is the view of the Commission that PPS has met many of its goals. The rate of growth in Medicare's inpatient expenditures has moderated. In recent years, however, hospital margins under PPS have fallen precipitously, partly because of large and unexpected cost increases. We have not found evidence of substantial or systematic changes in quality of care received by Medicare hospital patients since the implementation of PPS. Nor have we found evidence of a major reduction in the diffusion of new technology. On the other hand, we have witnessed an increasing number of hospital closures. ProPAC is currently studying this trend. Our early findings indicate that prior to closure these hospitals tend to have fewer admissions and lower occupancy rates than other hospitals of similar size. To the extent that hospitals are closing because they are underutilized or have long-standing financial problems, closure is appropriate, expecially when there are other hospitals in the area. It is necessary, however, to carefully examine hospital closures and to maintain access to needed services for Medicare beneficiaries.

These and other vital areas need much more research. We believe that PPS requires even more careful scrutiny today as the financing system becomes tighter. We also need to devote additional attention to the linkage between services furnished in the inpatient setting and in the outpatient and ambulatory care settings.

In some sense, we are really at the beginning of PPS. The first five years were needed to become accustomed to the system, to make some basic adjustments and correct initial errors. Now we are in a position to observe the longer term impact of a more tightly controlled payment system for Medicare than has ever existed. We at ProPAC are anxious to help the Congress and the Secretary as we enter the second five years of PPS, and will be pleased to continue to assist in whatever way you wish.

I would be pleased to answer any questions you or the members of the Subcommittee may have at this time, Mr. Chairman.

EXHIBIT I

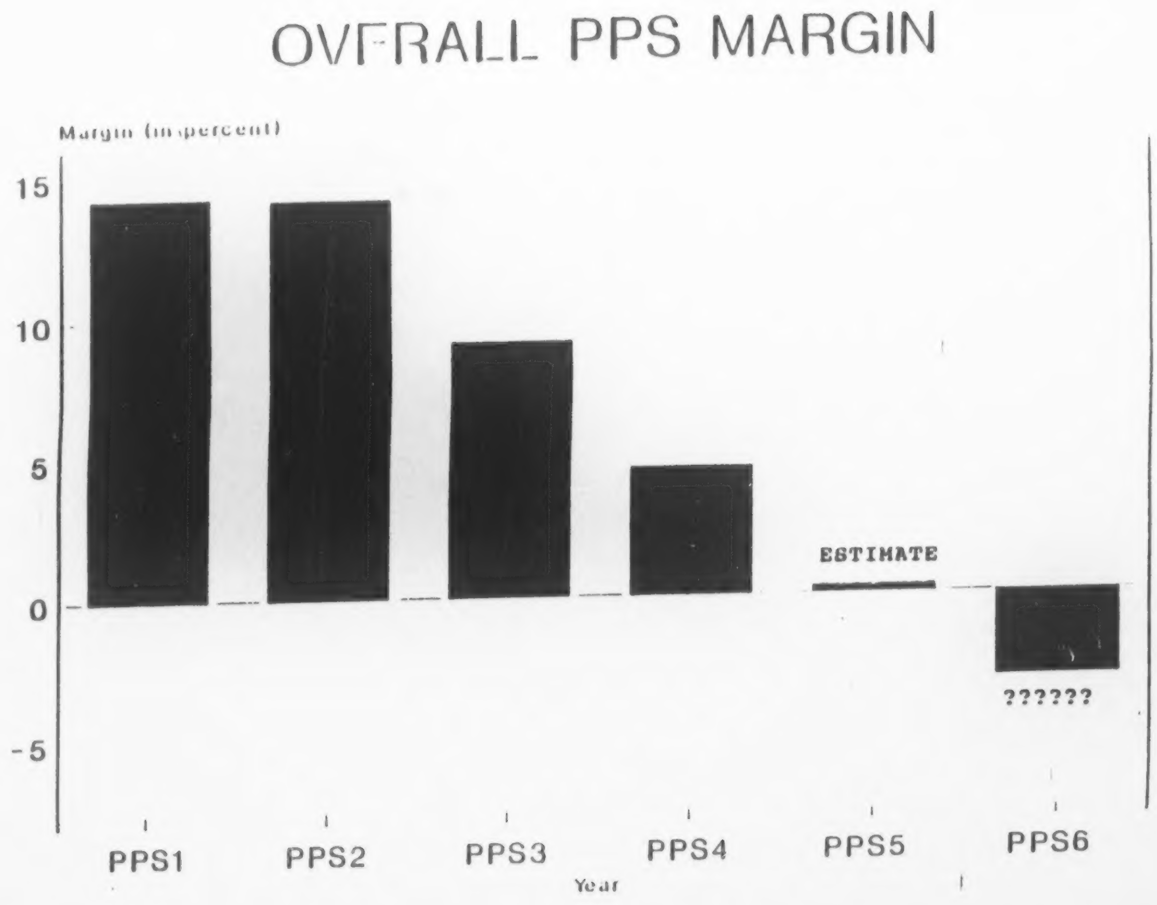

OVERALL PPS MARGIN
Margin (in percent)
15
10
5
0
-5
ESTIMATE
??????
PPS1
PPS2
PPS3
PPS4
PPS5
PPS6
Year

EXHIBIT II

Cumulative PPS Cost and Payment Trends

Percent Change First Four Years

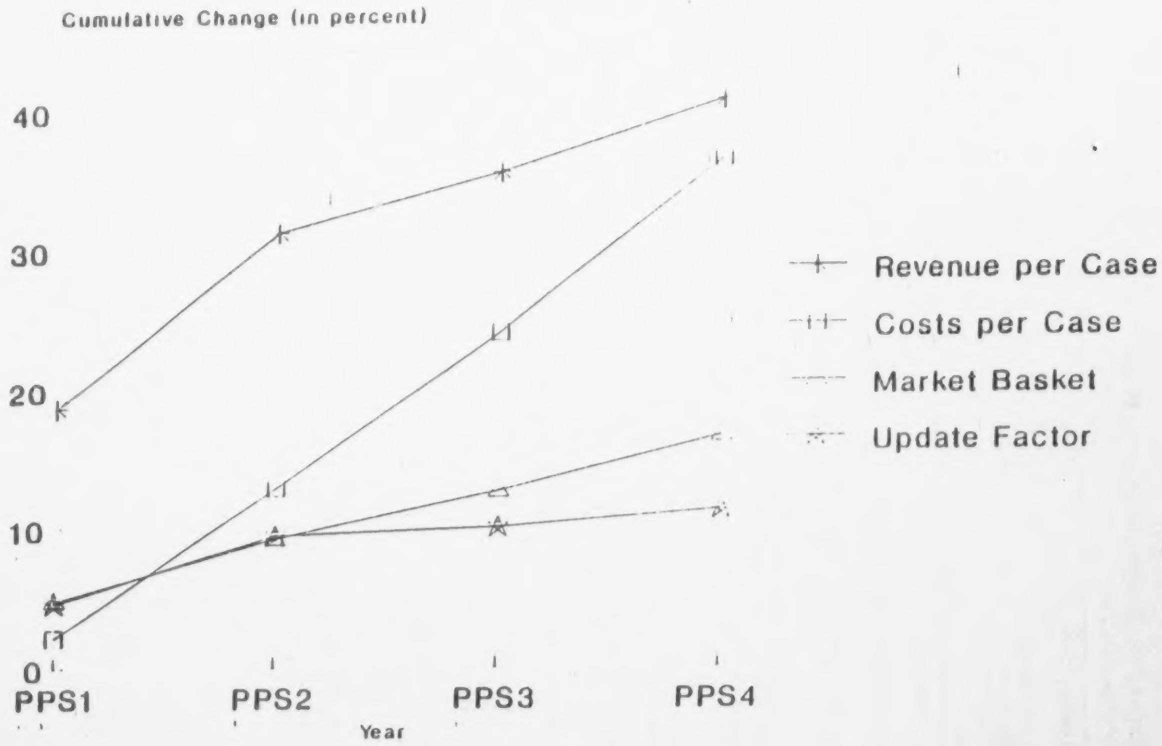


EXHIBIT III

Estimated PPS Update Factors for Fiscal Year 1990 Under ProPAC Recommendations

Total Update Factor	
Average update factor	4.9%
Large urban	5.0
Other urban	4.5
Rural	5.6
Components of the Update Factor	
Components applied to all hospitals:	
Fiscal year 1990 market basket forecast[a]	5.7%
Correction for fiscal year 1989 forecast error[b]	0.6
Components of discretionary adjustment factor	
Scientific and technological advancement[c]	--
Productivity[c]	--
Total discretionary adjustment factor	0.0
Case-mix change	
Total DRG case-mix index change	-3.0
Real DRG case-mix index change	1.5
Within-DRG patient complexity	0.8
Net adjustment for case-mix change	-0.7
Components applied to urban hospitals only:	
Third-year phased reduction to standardized amounts	
Adjustment for large urban areas	-0.8
Adjustment for other urban areas	-0.8
Urban population differential	
Adjustment for large urban areas	0.2
Adjustment for other urban areas	-0.3

[a] Forecast of ProPAC-recommended PPS market basket by Data Resources, Inc.

[b] The market basket forecast used for the fiscal year 1989 update was 5.4 percent. The most recent fiscal year 1989 forecast is 6.1 percent. The full difference is not adjusted because no correction is made for errors in forecasting hospital industry wages.

[c] In the Commission's judgment, the added costs for scientific and technological advancement should be funded by increases in hospital productivity. Therefore, these components of the update factor sum to zero.

Chairman **Stark**. Thank you Stu. Going back on the broad approach to the prospective payment system, it seems to me that up until now, we have not let it work.

We have said there will be a national rate and yet we've postponed going to a national rate. And we have said we won't try and bail out segments, we won't do special things for inner-city or teaching hospitals.

And, as you so aptly observed, the Chair had to eat those words every one of the 4 years we've fussed with this system.

You've also said that if I pushed you that you wouldn't go to a complete line item utility-type control each cost, and control each——

Mr. **Altman**. I would not——

Chairman **Stark**. Isn't the other side of that then, that we have to swallow the politically distasteful consequences from time to time?

And that is that some hospitals like the ones you've mentioned in my district that's Humana, are reaping off 30 percent profits.

Mr. **Altman**. I didn't say that.

Chairman **Stark**. I said that.

And other hospitals are closing because they may have too little occupancy. Maybe they have bad management. Maybe they have a whole host of problems.

But we don't let that happen. We come in at the last minute and adjust and fuss. I suspect what you're saying is that if this prospective payment system is going to work, we have to be willing to face the consequences, and those may result in the loss of profit, and in some hospitals closing.

If we don't do that, the system is just going to go along not working very well.

Mr. **Altman**. Partly I said that the other thing that really troubles me, as I indicated, is the roller coaster that hospitals have been on.

In the first year of PPS, hospitals embarked on what was an extraordinary belt tightening. We saw costs actually going down.

We saw much tighter controls. We saw admissions going down. And then we poured literally billions of extra dollars into the system. And it's hard to know exactly what happened, but we saw a tremendous jump in those costs.

Now to some extent it was maybe that they felt they cut too much. But to another extent, I'm sure it was the result that they found, low and behold, that these cost cuts were painful.

Hospital administrators will tell you time and again that many of the decisions are not made by them. We do not have the physicians under the same payment system.

We have JCAH requirements that force hospital administrators to do things. Mrs. Johnson indicated a lot of the decisions that are made by hospital administrators are not within their power.

The other thing that I have been championing lately, we have to understand that our hospital industry and our medical care system was designed in the fifties, sixties and seventies.

It is staffed up assuming, quite frankly, low wages. And low wages of highly trained nurses. Now nurses are getting what many of us believe they should have gotten a long time ago.

The question becomes whether we can both have the old staffing ratios and the new payments. Now to ask hospitals overnight——

Chairman STARK. Haven't staffing ratios actually been going up as fees have been increasing?

Mr. ALTMAN. Now, the problem on the hospital administrator's side—to ask them overnight to sort of adjust—they can't do it.

That is one of the reasons we have recommended a much more modest reduction. And in fact, if you really added up all the numbers we are recommending, we are recommending an increase in total hospital budgets that could be close to 10 percent.

The ProPAC recommendations, we believe, are fair. They are above market basket. And given all the pressures on hospitals, I believe they are fair.

But over time, we have to see those staffing ratios change or else we just, in fact, are gonna write 15, 20 percent a year increases in checks.

So this bigger picture is there. And I'm very concerned about this kind of problem, where an industry sort of goes up and down like a sine curve. It doesn't make a lot of sense to me.

Chairman STARK. Thank you.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Dr. Altman, toward the end of your statement, you summarize by saying, and I quote, "In some sense, we are really at the beginning of PPS."

I wonder whether the reality is not that in a very real sense we are at the end of PPS. In these annual collisions between Medicare hospital reimbursement and budget pressures, hospital reimbursement loses every time. We know that. It is going to happen again this year. It is just a question of degree.

Don't we have to start over and develop some new strategy for hospital reimbursement rather than trying to fine-tune a failing system?

Mr. ALTMAN. Mr. Gradison, I personally do not believe the system is failing, and I do not think the Commission believes the system is failing.

The CBO estimates are that, if left alone, payments to hospitals will go up by 13 percent. Thirteen percent. The Medicare program is the largest growth item in the whole Federal budget, aside from maybe interest on the debt. When we talk about reductions, we are talking about reductions from very big increases.

Now, I am not suggesting, and the Commission is surely not suggesting, reductions in the rate of increase anywhere near the President's budget. As I said, my quick calculations are if you accepted the ProPAC estimates, the increases would be above 10 percent in terms of total outflows from the Medicare trust fund. I have to believe that given the amount of money we are spending in total, that should be adequate, particularly when you compare our system to that of any other countries in the world, including countries that do not do a bad job.

I mean in terms of access, if you compare us to Canada, there are people who go into the hospitals as often as we do; they stay there longer; they manage to come out as often as our people do. And somehow they are able to do it for substantially lower amounts of money. Their staffing ratios are significantly lower than ours. They pay their people somewhat less.

So I do not think PPS is failing. I think for the first time in a long time—maybe before Medicare they had the same thing—hospitals are faced with very tight budgets. And they are trying to deal with it. In many respects, you might say budgets were too tight. That is why we are recommending a little easing.

But I think PPS gives some good incentives. It is not an all-bad system.

Mr. GRADISON. Well, I do not want to put words in your mouth. I am really trying to understand what you are saying. What I think I hear you saying is that the complaints we are receiving from hospitals are a sign that the system is working, not that the system is failing. Would you comment on that?

Mr. ALTMAN. Well, you know, it is sort of easy and perhaps flippant, in ways, to talk about it that cost-based reimbursement allows all this inflation to go on, and what we need are tough constraints and people to meet budgets and all that kind of stuff. And, in fact, that is what is now happening. The truth of the matter is that no one likes to do it.

I live in a declining industry—the American university. We have had to meet declining budgets year in and year out even though our tuition has continued to go up very high. We have had to pay very tough prices.

I mean, I wish average academic salaries had gone up nearly as much as average salaries in hospitals.

I do not like where we are. I am sure the president of our university does not like where she is.

Yes. I think, in a way, hospitals have faced it. Now, you could argue that the pressures they are faced with are too tough, and we ought to leave off a little bit.

Unfortunately, the choice is quite simple. That is, we can wander back into cost-based reimbursement, allow the system to pay what the hospitals say they need—and I am sure they believe what they are saying. Or we can establish constraints, and once you establish constraints you are implying that somebody else is saying they cannot have what they say they want. Then it is a question of how tight those constraints are.

ProPAC suggesting that the constraints are a little too tight and we should let off a little bit, but we are not suggesting that you should just open up your hands and let the system have whatever the system wants.

Mr. GRADISON. One final question, if I may, Mr. Chairman.

Mr. Altman, are you concerned about the possibility that if we pay more, other payers are just simply going to negotiate for lower payments for themselves and that the hospitals will not collect more money but will be substituting Federal dollars for private dollars?

Mr. ALTMAN. I think the opposite is probably what is happening. I recently gave a speech to 250 treasurers of our largest corporations. I thanked them for becoming our Government.

I think we have asked our large corporations to do what in most other countries are done by their governments. Our large corporations now pay for their own employees, for their dependents, for the uninsured, for shortfalls in Medicaid and Medicare. They did not ask for this honor. Quite frankly, they are a little annoyed.

So, to some extent, to the extent that it substitutes, I do not think that is necessarily a bad thing, and probably gets back a little closer to what the right amount is. Our American corporations—I am sure you know this better than I do—are more than a little annoyed. They are very annoyed. They believe they are being cost-shifted against very substantially, and I think they are right.

Mr. GRADISON. Well, I do, too. That is why I was wondering if we put more money on the table, with the present frame of mind of American corporations, they are not going to come back and say: We have been overpaying you all these years.

Mr. ALTMAN. Oh, I suspect they would.

Mr. GRADISON. Since you are getting more money from Medicare, we want lower rates for the folks for whom we are paying. And if that happens to any large extent, the hospitals do not end up with any more money. It is simply that more comes from the Federal Government, less from the corporations. The hospitals are still in a jam.

I am not predicting that, but I just wonder whether that is not a possibility. And would that not be consistent with the attitude that you've run into?

Mr. ALTMAN. Our corporations may say that. I do not think they would win. It is interesting to talk to them. I mean, they think of themselves as pretty big, particularly our very big corporations. But when it comes to power they have on our medical care system, they are not all that big. And except for a few areas where one or two corporations dominate, they can say anything they want. But I think hospitals faced with these higher costs are not going to give them back.

Mr. GRADISON. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Mr. Altman, you testified that we continue to see the pattern of hospital closings, and that among the hospitals that have closed, a majority have been in the urban areas.

Mr. ALTMAN. Yes, sir.

Mr. COYNE. Do you have any thoughts about why that is the case?

Mr. ALTMAN. Well, let me just give you some of the facts. First of all, what we have found so far—and I want to emphasize this is preliminary, and we do not have hospital-by-hospital data—96 percent of the closed hospitals had fewer than 200 beds. Of that, while 50.4 percent of the closed hospitals were in rural areas, 37 actually were for profit. And what you wound up with is that within the hospitals with 200 beds or less, the urban closure rate was higher. The reason why it probably was higher is that there are more substitutes available in urban areas than in rural areas.

But as has been pointed out today, I think the problem of access is much more serious in rural areas. So I am in no way diminishing the discussion earlier this morning.

An urban hospital that closes, there might be a hospital four blocks, five blocks away, or something like that, or even a mile away. But what you heard this morning is that you might be talking about 50 miles when you deal with rural closures. So I do not want to overdo that.

But also what our data shows includes things like most of the hospitals that have closed had between 30 and 60 percent fewer admissions than those that stayed open, for the same size hospital. Almost 50 percent of the hospitals that closed were not JCAH accredited. So you are dealing with quality; you are dealing with admissions. The costs per case were between 10 and 50 percent higher in those that closed versus those that stayed open. Closed hospitals had longer lengths of stay.

Actually, what is quite interesting, when hospital administrators were asked why they closed, less than one-half of those interviewed cited PPS as the factor related to the closure. In other words, they are facing a multitude of problems, and PPS is only one of them.

Interestingly enough, while a majority of the closed hospitals had negative PPS margins, actually some of them were making money on Medicare. The problem was Medicare by itself was too small a percentage of their base, and they could not make up for the fact that they had low admissions, many of their people were on Medicaid, hospital bills were not being paid, and so they could not balance. As we indicated, they could not average.

Medicare alone is not the only problem, and it is hard for me to imagine, unless you are prepared to go significantly above the urban rates, that Medicare alone is going to be able to solve that problem. And yet the problem is very real, and it is multi-faceted. At least, that is what these numbers indicate.

Mr. COYNE. Do you have any statistics that indicate the percentage of profitable hospitals?

Mr. ALTMAN. In the closures or in total?

Mr. COYNE. Total.

Mr. ALTMAN. Well, the numbers I have before me, I hasten to say, have quickly become out of date because the world changes so quickly, as Mrs. Johnson pointed out.

In the fourth year of PPS, which would be 1987, we had 46 percent with negative margins, yet 17 percent of the hospitals still had margins in the 90th percentile, which were above 20 percent.

We recently saw numbers from the AAMC looking at teaching hospitals, and they showed that, on average, teaching hospitals were losing money, but that there were a few of them that were making more than 30-percent profit margins.

I hesitate to give you the exact numbers because the numbers we have are really out of date.

Mr. COYNE. Could you provide that?

Mr. ALTMAN. Yes, definitely.

Mr. COYNE. Thank you.

[The information of Mr. Altman follows:]

The table below indicates the percentile distribution of PPS hospital operating margins, as well as the percent of hospitals with negative margins, for the first four years of PPS. This table, containing preliminary estimates, will be updated in ProPAC's June 1989 report to Congress PPS and the American Health Care System.

Table   Percentile Distribution of PPS Operating Margins and Percent of Hospitals with Negative Margins for the First Four Years of PPS

	PPS1	PPS2	PPS3	PPS4
10th Percentile	-8.0	-8.7	-19.0	-24.3
25th Percentile	2.4	2.2	-4.8	-9.5
Median	11.0	10.6	5.1	1.6
75th Percentile	17.5	17.9	13.2	10.2
90th Percentile	23.3	24.3	20.2	17.8
Percent With Negative Margin	19.0	19.7	33.6	46.0

Source: Preliminary ProPAC estimates based on Medicare Cost Report data. Excludes hospitals in Maryland, New Jersey, Massachusetts, and New York.

Chairman Stark. Mr. Pickle.

Mr. Pickle. Thank you, Mr. Chairman.

Mr. Altman, I asked earlier of other witnesses, and I will ask you: Do you have data to show why these rural hospitals are being closed now?

Mr. Altman. Well, again, what we have been trying to do is look at all the closures, both urban and rural, look at the admissions beforehand, their PPS profit margins, the quality and so on. And I have just been able to give you the averages. I cannot yet give you hospital by hospital. We hope to have better information shortly.

Mr. Pickle. Well, I would ask that you give us that information. It seems to me that it ought to be a fact known, if, indeed, rural hospitals are having to operate at just as high an expense level as the urban. That is either yes or no, and there might be some factor to explain why. But we need that.

Now, until we know that, it seems to me like we have to take somebody's word. The rural hospitals tell me that their costs are terrible and that they have gone up and that they cannot compete. I have a feeling that they are correct.

I am trying to make a survey in my district of it. It seems to me that HHS ought to go into this with some speed to try to find out just exactly what are the facts on it.

Mr. Altman. I can tell you what we do know, and that is, if you look at urban and rural as a class, there is a 40-percent differential between the costs, on average, of urban hospitals and rural hospitals. Rural hospitals are 40-percent lower than urban. A great bulk of the difference between that, however, is accounted for by higher wages, sicker patients in urban areas, disproportionate share and so on. So when you finally squeeze it all together, there is a 14-percent differential that seems to continue to exist, at least in the standardized amount.

Our information suggests that the costs are lower, and significantly lower.

Mr. Pickle. Whatever are the facts that would base your decision, we need to know that.

Mr. Altman. Yes, sir.

Mr. Pickle. And it is not just wages. You have got a wage survey——

Mr. Altman. No, this is total cost.

Mr. Pickle. It is total cost.

Mr. Altman. Total cost, yes, sir.

Mr. Pickle. And we need to know that as a matter of fact. That ought to be established as quick as possible.

Now, in your testimony, you recognize the fact that the average PPS margin will fall below zero in the sixth year of the PPS.

Mr. Altman. Yes, sir.

Mr. Pickle. That is, unless hospitals slow down the rate of cost increases.

Now, what sort of a decision would a hospital have to make to hold down these increases on a case-by-case basis?

Mr. Altman. Well, you know, it is hard for me to sort of generalize. As a matter of fact, it is impossible. Costs run right through. The big hospitals in urban areas are several hundred million dollar enterprises. They spend a lot of money on a lot of things, and it is not all on patient care.

Mr. PICKLE. Well, let me put it differently to you, then. You have just stated that your surveys show that hospitals that were closed, only 1 percent of them, roughly—a very small amount—say that the cause for closing was lack of reimbursement from Medicare.

Mr ALTMAN. Yes.

Mr. PICKLE. Now, every newspaper article I pick up in my State where the hospitals have closed, it says "Hospital closed because Medicare reimbursement is insufficient." That is the headline; that is the feeling of the public. I am wondering is that the case.

Now, you are saying to me that is not the reason they list to you, or your facts did not show it, and the question that comes to my mind is: If they are being reimbursed, generally at the right level—the PPS level is approximately correct—then I assume you are saying that the hospitals are still not holding their costs down; and that the fault, if any—if it is a fault—is that the hospitals are not cutting out a lot of their services. And it is not the reimbursement. It is the fact that they continue to give services.

Now, is that correct or not correct?

Mr. ALTMAN. No, I do not want to say that. What I said was—first, let me suggest that the survey that I quoted was done by Mullner and Mayer, one in 1988 and the other one in 1987. We will make that survey available to you. [See p. 54].

Mr. PICKLE. All right.

Mr. ALTMAN. Second, what I was trying to say is that often, not only in rural hospitals but in urban hospitals—I know in Massachusetts as well as in New York—they have looked to Medicare to make money to counterbalance lower payments for uninsured patients, Medicaid paying at 60 and 70 cents on the dollar, and a variety of other extra costs. So, actually, what developed was Medicare as the, if you will—forgive me—the deeper pocket. Now, when that deeper pocket became less deep and, in fact, became a nonpocket and they faced these other losses, even if Medicare paid its costs, it was not enough for them.

We see that in Massachusetts today, and I am sure it is much more serious in rural areas. So the problem often is—and cutting costs, again, a hospital needs certain staffing ratios in order to stay open. So when its admissions fall, it cannot cut its costs.

Several of you have suggested maybe what we need is not a hospital as we know it, some kind of surgi-center, some kind of medical care that is less than a hospital. But given that you have the hospital open, they need to be staffed up at certain ratios. Therefore, if their admissions are not up to a level, their costs like they are very high, but they are not being inefficient.

I would suspect these hospital administrators are doing everything they can.

Mr. PICKLE. Well, we all give them the benefit of that doubt, and neither one of us wants to make that accusation. But if reimbursement is at a proper level, you do have to ask that question.

You have testified that hospitals continue to average more Medicare revenue per case than the costs incurred. You just got through saying that. Now, how do I reconcile that to my hospitals back in my district?

Mr. ALTMAN. Well, again, I was referring to hospitals in large urban areas where, in fact, Medicare—if you just looked at Medicare costs and Medicare revenues, were generating profitable margins until this year. And some hospitals continue to do it. Yet those hospitals, when they looked at their total, were losing money.

Mr. PICKLE. Well, I will ask you once more. Give this committee your judgment, representing the agency: What are the costs for these rural hospitals?

Mr. ALTMAN. Yes, sir.

Mr. PICKLE. Either that directly or vis-a-vis the urban hospitals. We need to know that as a fact. If the costs are just the same, then that differential ought to be closed. You could not justify doing it differently if the facts show that. So we need to establish those facts, and we need to establish them as quickly as we can, it would seem to me.

Mr. ALTMAN. Well, let me make a case for the possibility of paying them more than their costs. I mean, I personally can see some justification under Medicare for paying certain rural hospitals more than their costs, because we need them for access and admissions. And just looking at Medicare costs is too narrow.

I think you can make the case for higher than their costs. The question is: Can it be any number? It is at that point that the answer is probably no.

I think you are going to need to pay under Medicare more than their costs in order to keep these institutions open.

Mr. PICKLE. Well, then, why aren't the rural hospital beds filled?

Mr. ALTMAN. I do not know.

Mr. PICKLE. That is the question.

I had a hospital close in my district, and at the time it was closed, there were four beds filled. It was a small hospital. I only think it had about 25, but four beds were filled. No hospital can stay open. They closed a hospital in my city last week, and the headlines says, "Hospital closed because reimbursement inadequate."

Now, the organization which controls that hospital closed it because the costs were too high. They were not making any money. It was not being filled, and they are going to convert it to a different use type hospital

Mr. ALTMAN. Right.

Mr. PICKLE. Presumably for a lot of other medical purposes. But the public is being told it was caused by Medicare itself. Now, that is not correct.

Mr. ALTMAN. That is right. It is not correct.

Mr. PICKLE. Somehow we have got to try to establish that.

Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Thank you for your testimony, Dr. Altman.

[The following was subsequently received:]

Trends in Hospital Closures[8]

Information on hospital closures has sparked continued debate over the need for downsizing the industry while maintaining access to care. Community hospital closures totaled 343 for the period 1980 through 1987. Although there has been disagreement about the actual number of closures, according to the AHA some 81 community hospitals closed in 1988, a 1.3 percent increase since 1987. While the number of closures has increased, the reduction in the number of beds has been partially offset by hospital openings. During 1988, 44 new hospitals opened.[9]

Small hospitals have dominated the number of facilities that closed. Ninety-six percent of closed hospitals had fewer than 200 beds; most, in fact, had fewer than 50 beds (see Table 4-10). Even though two-thirds of open hospitals with fewer than 200 beds were rural, only 50 percent of closed hospitals were rural.[10] The proportion of closed hospitals in rural areas has increased steadily since 1983. At the same time, the proportion of closed hospitals in large metropolitan areas has been declining.

The characteristics of most hospitals that closed differ from comparable facilities that remained open. Fewer than 47 percent of closed hospitals were accredited by the Joint Commission for the Accreditation of Health Care Organizations (JCAHCO), compared with 66 percent of open

Table 4-10. Characteristics of Open and Closed Hospitals

	Closed Hospitals (1980-1987)	Open Hospitals (1984)			
			Fewer Than 200 Beds		
	All	All	All	Urban	Rural
Total number of hospitals reporting	248	5,524	3,775	1,302	2,473
Size					
6-24 beds	18.1%	3.6%	5.5%	1.9%	7.4%
24-49 beds	36.7	16.6	24.9	11.5	32.3
50-99 beds	26.2	24.1	34.6	31.8	36.1
100-199 beds	14.9	24.1	35.0	54.7	24.2
200-299 beds	2.4	13.0	–	–	–
300+ beds	1.6	18.6	–	–	–
Ownership					
Public	21.8	29.1	35.8	18.4	45.0
Private, nonprofit	41.1	57.3	48.2	53.1	45.7
Proprietary	37.0	13.5	16.0	28.5	9.3
Community type					
Non-MSA	50.4	48.0	65.5	–	100.0
MSA <2.5 million people	31.5	41.6	29.0	84.2	–
MSA >2.5 million people	18.1	10.4	5.5	15.8	–
Census division					
New England	1.2	4.4	3.5	4.5	3.0
Middle Atlantic	9.7	10.3	5.6	10.0	3.3
South Atlantic	7.3	14.4	13.0	14.1	12.3
East North Central	14.1	15.2	13.2	14.1	12.8
East South Central	5.6	8.7	10.0	6.2	11.9
West North Central	10.9	13.5	17.1	5.9	22.9
West South Central	29.8	14.0	16.5	15.7	16.9
Mountain	4.4	6.4	7.5	3.4	9.7
Pacific	16.9	12.0	12.4	23.5	6.6
Teaching affiliation	3.2	15.6	2.0	4.5	0.6
Accreditation	46.8	75.1	65.6	79.7	58.2

Note: Of the 343 hospitals that closed from 1980 through 1987, the American Hospital Association Annual Survey had complete data only for 248. These 248 closed hospitals had a total of 18,114 beds.

SOURCE: Analysis of American Hospital Association Annual Survey data for ProPAC by Jack Hadley, Ph.D.

hospitals with fewer than 200 beds. In addition, very few closed hospitals had residency training programs approved by the American Medical Association (AMA). Further, 16 percent of open hospitals with fewer than 200 beds were for-profit, compared with 37 percent of closed hospitals. Closed hospitals were also much less likely to be government-owned hospitals.

Compared to open hospitals with 200 or fewer beds in the same year, hospitals that closed between 1983 and 1987 had substantially higher costs, with average costs 21 percent to 51 percent higher than open hospitals (see Table 4-11). Low occupancy and declining admissions appear to be associated with closed hospitals' relatively poor cost experience. Compared with open hospitals, admissions ranged from 31 percent to 61 percent lower, while average occupancy ranged from 17 percent to 38 percent lower. Higher costs, lower occupancy, and lower admissions among closed hospitals were evident as early as 1980.

Average length of stay was consistently longer in closed hospitals in the year before closure, ranging from 3 percent to 26 percent higher than length of stay for open hospitals. Consistent with their higher average costs per case, closed hospitals seemed to employ substantially more personnel per admission than open hospitals. FTEs per admission in closed hospitals ranged from 12 percent to 40 percent higher than FTEs per admission in open hospitals. The proportion of Medicare patients varied from 7 percent more to 25 percent less in hospitals that closed compared to open hospitals with less than 200 beds.

Table 4-11. Comparison of Selected Characteristics for Closed Versus Open Hospitals with Fewer Than 200 Beds

	Year of Closure				
	1987	1986	1985	1984	1983
Admissions					
One year before closure	-31%	-61%	-35%	-49%	*
Two years before closure	-35	-59	-38	-54	-22%
In 1980	-28	-43	-24	-48	-16
Occupancy					
One year before closure	-28	-38	-22	-30	-17
Two years before closure	-27	-30	-15	-17	-19
In 1980	-7	-22	-16	-9	-13
Cost per case					
One year before closure	21	10	45	29	51
Two years before closure	7	14	25	21	39
In 1980	11	5	19	15	36
Average length of stay					
One year before closure	26	5	22	4	3
Two years before closure	11	15	7	22	5
In 1980	6	4	16	21	9
FTEs per admission					
One year before closure	23	12	32	40	26
Two years before closure	14	37	21	25	23
In 1980	13	16	32	10	21
Percent Medicare discharges					
One year before closure	1	1	7	18	-25
Two years before closure	6	4	-6	5	-18
In 1980	8	-1	1	4	-20
Payroll cost as percent of total costs					
One year before closure	-5	-2	-3	10	-1
Two years before closure	-10	-1	-2	4	-1
In 1980	-2	-4	3	5	-5

* Closed hospitals reporting for this year are still under investigation.

SOURCE: Analysis of American Hospital Association Annual Survey data for ProPAC by Jack Hadley, Ph.D., 1988.

Analysis of PPS margins for closed hospitals indicates that a majority had negative PPS margins for one or more years before closure.[11] PPS margins for these hospitals tended to be among the lowest in the distribution across all hospitals. However, not all closed hospitals had negative PPS margins; some had sizable PPS margins even up to the year prior to closure. For these hospitals, other factors like overall financial status, ownership status, and competition may have contributed to the closure.

Competitive pressures, such as low occupancy and the availability of other hospitals in the county, are associated with closure. Closed hospitals were in counties with almost twice as many hospital beds as comparable open hospitals.[12] In addition, the counties in which closed hospitals were located had, on average, 2.5 other hospitals compared with 1.8 in similar counties where no closures occurred.

Administrators from rural hospitals that closed in 1987 cite many factors contributing to closure.[13] These include fewer admissions, fewer days of care, annual operating losses, competition from other hospitals, and reduced size of medical staff. Although PPS was among the many factors cited, it was reported by fewer than half of the administrators.

Clearly, data analysis and anecdotal reports indicate that declining utilization plays an important role in hospital closures. Competition from other hospitals, coupled with the more stringent payment environment of the mid-1980s, may have been a dominant reason for the recent increase in closures. There is concern that Medicare PPS policies may have contributed to the closure of some efficient hospitals and that some of the closed hospitals, regardless of their efficiency, may have served patients with no ready alternative sources of care. Future ProPAC study will focus on defining how and where access to care is affected, and what can be done in such situations.

Notes

8. Jack Hadley, Ph.D., performed a study of permanent community hospital closures for ProPAC, *Hospital Closures in the 1980s: A Preliminary Analysis of Data from the American Hospital Association's Annual Survey of Hospitals, 1980-1986*. His analysis compared characteristics of open and closed hospitals at specific points in time and over certain periods. Two hundred forty-eight hospitals had complete data for the analysis.

9. Correspondence from Carol M. McCarthy, president of the American Hospital Association, to Fortney H. Stark, chairman of the House Ways and Means Subcommittee on Health, U.S. House of Representatives, March 22, 1989.

10. For the AHA Annual Survey analysis, nonmetropolitan area was used as the proxy for rural hospital.

11. Analysis of closed hospitals' PPS margins was performed by ProPAC using Medicare Cost Report data.

12. R. Mullner, R. Rydman, D. Whiteis, et al., "Rural Community Hospital Closures in the United States: An Epidemiologic Matched Case-Control Study," found in the literature search in S. Boeder, ed., *Rural Hospital Closure* (Chicago, IL: American Hospital Association, 1989).

13. M. Taggert and R. Mullner, "Why Rural Hospitals Close: The Perceptions of Their Administrators," in S. Boeder, Ed., *Rural Hospital Closure* (Chicago, IL: American Hospital Association, 1989).

From: Prospective Payment Assessment Commission, *Medicare Prospective Payment and the American Health Care System*, Report to the Congress, June 1989, pp. 110-112.

Table 5-8. Average Fourth-Year PPS Medicare Operating Costs per Case, by Hospital Group

Hospital Group	Average Costs per Case	Percentage Difference from Average Costs per Case for All Hospitals
All hospitals	$ 4,004	–
Urban	4,427	10.6%
Rural	2,684	-33.0
MSA >1 million	4,862	21.4
Other urban	3,976	-0.7
Rural referral	3,156	-21.2
Sole community	2,952	-26.3
Other rural	2,434	-39.2
Major teaching	6,133	53.2
Other teaching	4,539	13.4
Non-teaching	3,444	-14.0
Disproportionate share:		
MSA >1 million	5,314	32.7
Other urban	4,064	1.5
Rural	2,232	-44.3
Non-disproportionate share	3,793	-5.3
New England	4,377	9.3
Middle Atlantic	4,258	6.3
South Atlantic	3,789	-5.4
East North Central	4,215	5.3
East South Central	3,065	-23.5
West North Central	3,624	-9.5
West South Central	3,563	-11.0
Mountain	3,773	-5.8
Pacific	4,844	21.0
Urban <100 beds	3,494	-12.7
Urban 100-249 beds	4,049	1.1
Urban 250-404 beds	4,367	9.1
Urban 405-684 beds	4,807	20.1
Urban 685+ beds	5,491	37.1
Rural <50 beds	2,199	-45.1
Rural 50-99 beds	2,425	-39.4
Rural 100-169 beds	2,752	-31.3
Rural 170+ beds	3,169	-20.9
Voluntary	4,127	3.1
Proprietary	3,840	-4.1
Urban government	4,436	10.8
Rural government	2,485	-37.9

Note: Excludes hospitals in Maryland and New Jersey.

SOURCE: ProPAC estimates based on Medicare Cost Report data from the Health Care Financing Administration.

From: Prospective Payment Assessment Commission, *Medicare Prospective Payment and the American Health Care System*, Report to the Congress, June 1989, p. 133.

Mrs. JOHNSON. On page 8 of your testimony, you make the statement that, "It is the Commission's opinion that any cost increase related to scientific and technological advancement should be offset by increases in hospital productivity."

Now, I find that statement very hard to understand in the context of the experience of my hospitals. For example, if you have to use more sophisticated drugs—a scientific advancement—and they are more expensive, there is no offset in productivity.

Now, you could say that perhaps in the case of the heart injection you would get the patient off to a better start. Maybe you do not have to keep them in the hospital as long. But I cannot imagine that every scientific or technological advancement can create increased productivity and reduce costs. Certainly, ultrasounds do not do that. It enables us to function at a higher standard of care, but I do not see how they create increased productivity and reduce costs. You are implying here that as hospitals use better equipment, it costs you less per unit—sort of like manufacturing.

Mr. ALTMAN. I am sorry if that sentence left that impression. We were talking not patient by patient. We were talking about hospital by hospital and system by system.

Mrs. JOHNSON. But your second sentence, right, goes on to say system by system, but on what basis do you make the statement "new and important technologies or procedures should be purchased by hospitals with money saved by encouraging improved productivity"?

Mr. ALTMAN. First, let me make the distinction between two types of technology improvement. To the extent that we move higher cost technologies into higher DRG's, hospitals will be paid more. To the extent that over time a particular procedure or a particular diagnosis is treated by more complicated procedures, the system will respond by putting a higher weight to that particular diagnosis, and that DRG reimbursement will go up.

What we are talking about here, or what I was talking about, is in the short period of time there are in every year new technologies that come on line that are not adequately reimbursed by a higher DRG. We estimate that, on average, that is around 0.5 percent. That is what it turns out to be. We have calculated procedure by procedure for the last 3 years, and we have added it up. It averages around a half a percent for the system as a whole.

What we are saying is that every industry should be faced with economic pressures to become more efficient, on average, and that the industry as a whole ought to be able, on average, to be 0.5 percent more efficient, not patient by patient. So that if everything else was paid for adequately, what we are talking about is that half a percent balancing out.

In the beginning, we used to think it was at 1½ to 2 percent. In fact, we found out that this new technology that is not reimbursed is closer to a half a percent. So that is what it is.

Mrs. JOHNSON. You made the statement assuming everything else is reimbursed adequately. When you look at Medicaid reimbursements, it is an assumption that you cannot make. So that is a bigger discussion, but I have a better understanding of why you made that statement.

Mr. ALTMAN. Yes. And I apologize for not making it clearer.

Mrs. **Johnson**. All right. It deserves more attention, though, than we are giving it here, because while it may be true, grossly, nationally, it is one of those statistics that could kill a small hospital.

Mr. **Altman**. Yes.

Mrs. **Johnson**. And in a small hospital, it is inapplicable. But I want to move on to something else.

You mentioned that within the system there is tremendous variation—an important statement—and that there are hospitals that are experiencing 30-percent profit margins. Now, recognizing that you do not want to get into a line item regulatory mechanism—and I agree with you on that—nonetheless have you looked into why these hospitals are able to make a 30-percent profit?

Mr. **Altman**. We are in the process of looking at that, not so much to pin blame on any one hospital, but to decide whether there is any part of the system that is out of whack.

But it is possible for hospitals that have very high occupancy rates, that are receiving large teaching adjustments, that are in certain areas of the country and receive other payments that are added on and added on, and have kept their Medicare costs lower, to wind up with these 20- to 30-percent margins. And in and of itself, as I said, it may not be anything wrong with the system; it just may be that they have managed to benefit from all the positives and not been hit by any of the negatives.

Mrs. **Johnson**. I am not at all implying that it is either good or bad that the hospital is able to benefit from the system. I do not think we can make any judgments. But I think that as policy-setters, we must know exactly why some are able to function this way, before we go on pressing on the generic costs as the primary lever we use to produce efficiency or productivity or whatever you want to call it. In contrast to the 30 percent that are making profits are 25 percent that we know are in desperate shape, and now more than 50 percent are losing money every time a Medicare patient crosses a threshold.

So I think this is a major issue, and until we can understand concretely that situation better, I do not see how we can endanger the hospitals at the other end of the spectrum. We can say to them: You, too, could be profitable if you would only modernize or whatever. Then we would be on firmer ground. We cannot say that, and we see desperately needed hospitals closing. I think that is something that we have to do a better job on. I do not think we can do it right now. Would you like to comment.

Mr. **Altman**. One, I would like Dr. Young to perhaps comment, because one of the issues that I think we should put on the table are differences in practice patterns, many of which hospitals administrators, if you get them on the side, are quite frustrated with.

Don, do you want to address that?

Dr. **Young**. We are attempting to understand that better. I think that is a fundamental question that you raise.

We know, for example, if you look at the frequency with which hospitals do major surgical procedures, in those that do them infrequently, they cost far more than in those that do them frequently. We also know from a quality of care point of view that hospitals that do them infrequently do not do them nearly as well. Mortality and complications are much higher. So one explanation is the frequency and the efficiency with which hospitals do major surgical procedures.

Another variable that we have looked at is the use of intensive care units.

Mrs. JOHNSON. Excuse me just for a moment. Do you have reason to believe that the hospitals with positive margins are hospitals that, indeed, do not try to do procedures that they do not do often?

Dr. YOUNG. We know our analysis to this point has looked at their likelihood of generating a profit on an individual case. Their likelihood of generating a profit on an individual case is much larger if they do the procedure frequently than it is if they do the procedure infrequently. And that is true across a number of major surgical procedures we have examined.

Mr. ALTMAN. Unfortunately, that argues for more concentration of these complicated procedures in fewer institutions. And, in fact, we have seen the opposite happening. We have seen a diffusion out rather than a concentration, against what we expected from the PPS incentives.

Mrs. JOHNSON. But in order to make policy decisions, we have to know whether those decisions are being better made in this 30 percent with a positive margin. One of the ways that some of us suspect those decisions are being made is that those hospitals have a better mechanism for not accepting complex Medicare patients.

Now, I do not know that that is true. There has just been some speculation in that regard. Do you have any reason to believe that some of the hospitals that have positive margins are also hospitals that have very tight policies and steer complex Medicare patients to other facilities?

Mr. ALTMAN. We do not have evidence on that, but I will tell you this: Some of the hospitals that have high profit margins are institutions that treat our most complex patients.

Mrs. JOHNSON. Well, I would appreciate it if you could help us look at this particular issue in the next month.

Mr. ALTMAN. You are absolutely right, and we will.

Mrs. JOHNSON. We have really got to get a better handle on it.

Mr. ALTMAN. We will try to provide you everything we have.

Mrs. JOHNSON. Secondly, you make the statement that because of the experience that Canada has had with its health care system that we are able to say PPS is at the beginning rather than at the end. The Canadian system, as compared to our system has markedly different costs for hospital stays. The implication is that Canadian hospitals provide less intensive care than do American hospitals, and I have discussed this with you all before.

Do we know anything about how the Canadians control intensity of care? Do we know how they make the decision when to buy new equipment—which has a lot to do with intensity—do we know how they regulate staffing patterns to keep the ratio of specialized personnel down?

What can you tell us about the quality issue, the judgments as to access to quality and other decisions that are being made by the Canadians, so that they can keep the costs of their hospitalizations down?

Mr. ALTMAN. Unfortunately, I think you have hit on a whole series of questions and we need to know more answers.

By the way, let me emphasize, I am not suggesting that overnight the U.S. system should become the Canadian system. On the other hand, I am suggesting that there is more than one way of doing things. And just because we are being told that our system needs more money and this implies that this is the only way to do it, the truth is that in anything we do there are opposite ways. And on any chart you look at, we are off the chart. In any international comparison, even accounting for our higher income and accounting for everything else, we are off the chart. It is not that we want to substitute their system for ours, but it does, at least in my mind, suggest that we have to ask tough questions, and they are exactly the questions you are asking.

I am working with several large foundations that are prepared to put very sizable amounts of money into answering just the questions you have raised. The information that is beginning to come out by researchers suggests that some of the shibboleths—poor quality, people not getting good care, not getting high-tech—are not true.

Now, what we do not know are the questions you raised. They are very good questions, and as a matter of fact, I am going to be working very closely over the next year in my research path to try to find answers to that. Because I am not sure there is a magic bullet there, but at least it is the kind of information that says we cannot just accept what we have as the only way. And that is all I am raising.

Chairman STARK. I will recognize, at this point, Mr. Levin, and the members can come around for a second time if we do not get all our questioning done in the first round.

Mr. LEVIN. Thank you, Mr. Chairman.

As always, it is illuminating to hear from you. Let us just spend 1 minute or 2 placing your testimony in I guess the most important context we are facing, and that is the budget. While you say that you do not draft these specifically taking into account the need to reduce the deficit, you have knowledge of the general picture.

The President's budget proposal would reduce this portion of the budget by about $1 billion in indirect medical education. Your recommendation, I assume, would eliminate most of that reduction. I am not sure you can do it just by fractions. There may be kind of a geometrical function here, right?

Mr. ALTMAN. We have tried to make this equation as complicated as we possibly could so that only four people understand it. So you are right.

Mr. LEVIN. Do they agree?

Mr. ALTMAN. And I am not one of them.

I think, first of all, our teaching adjustment has two parts to it. The reduction from 7.7 to 6.6, I think, is in the neighborhood of about $300 million. But we have recommended that since that money was taken out of the aggregate pool in the first place, it should be put back in there so that you make it budget neutral. And that is what our recommendation is.

Now, if you wanted to take the funds out of the program, it would affect the budget deficit, of course you could do that.

Mr. **Levin**. It is almost proportionate. Of the billion, $700 million more or less would be lost under your approach. Okay.

The capital reduction of over $1 billion, we are going to consider that 2 weeks from now, and you are working on that or not?

Mr. **Altman**. We have several times testified before this body that ProPAC believes that capital should be included in the DRG payments. We have not participated in your discounting mechanism as it has proceeded. So we have not testified on that, nor have we taken a position on it.

Mr. **Levin**. You are not now analyzing it? So you will not be here in a couple of weeks.

Mr. **Altman**. That is correct.

Mr. **Levin**. Okay. I do not mean that critically. We are just trying to assess the budget impact.

Mr. **Altman**. Well, to me, at one level it is unfairly simple; that is, well, you know, take 5 percent off, take 10 percent, take 15, take 20, take 25. Our sense in the beginning was that capital was unfairly receiving too much money compared to labor; therefore, that was one of the reasons for putting it into the DRG payment to begin with.

Whether the discount at 15 to 20 percent begins to make capital and labor more fair, I think it does. I do not think there is any magic number, though, and discount rates of 25 sound to me to be quite high. They really are going to discriminate against newer facilities.

Where that line crosses between 15 and 25 is purely arbitrary.

Mr. **Levin**. But you think, again, the budget proposal may be too drastic.

Mr. **Altman**. Twenty-five percent, again, there is no right number in this game, and it is not even close to being right. There is no right number.

You do know that if there is no discount, capital tends to be favored over operating budgets. As I said, at about 15 to 20 percent, you might feel that that is about as high or as tough as you want to be. We have not talked about it. My own sense is 25 percent sounds very tough.

Mr. **Levin**. All right. You are making our work tougher yet.

Now, the PPS update factor, you handle that differently than in the President's proposal. You assume differently on the market basket.

Mr. **Altman**. We have assumed the same market basket. We have used the DRI estimates, which are the estimates that are used by HCFA, and they are the same estimates that have been used since the beginning of PPS. We have not changed.

We have now seen floating around this town a whole bunch of new market baskets. Quite frankly, it troubles us. They may have more apples and peaches than they should.

My sense is that, to some extent, you can just take our numbers and substitute a new market basket. When we say we are 0.8 of a percent below the market basket, if you want to use the CBO market basket, then subtract it by 0.8 of a percent. So that part would be all right.

The market basket that OMB uses is, quite frankly, a bit of a mystery to us.

Mr. LEVIN. All right. That is helpful. I think it illustrates the bind that we are in, the task that we face, because the three major factors in the administration's proposal, each of them is affected or reflected on in your testimony, some very explicitly and others not so much so.

Just to finish, again, to show the stringency, the difficulties that we face, when you read your testimony on hospital closures, it says:

> To the extent hospitals are closing because they are under-utilized or have long-standing financial problems, closure is appropriate.

When you gave it to us an hour ago, you say "may be appropriate."

I think that would illustrate that again there is some real complexity there. And I think the complexity is further illustrated by Nancy Johnsons's question to you. You say you do not want regulation—and I do not think any of us really do—but you find the variation extremely troublesome?

Mr. ALTMAN. Yes.

Mr. LEVIN. But you do not give us at this juncture in your study that a path between the status quo and regulation.

Mr. ALTMAN. Well, if the budget—if aside from the budget deficit, and you can make the case that Medicare ought to worry about itself and its own internal financial security, and there are arguments that say that that is inappropriate to be playing with Medicare trust fund.

I think the path that we have put here would give hospitals a fair amount of new money. As I have said, our recommendations "could approach 10-percent increase in revenues." In many respects it exceeds 10 percent, and yet this also provides a tough set of constraints that say hospitals can do whatever they want, so that you—it does lay out a path.

Now the Congress runs into the problem when you get caught in this budget deficit. It is difficult for me to put myself in your shoes. I guess, quite frankly, what I would recommend is that after you have equalized as best as you can, which is what we tried to do, I would take it out of all of hospitals if you felt that you had to do it, and not try to——

First, what PPS has tried to do is equalize the system between classes of hospitals without having to do it by individual hospital. And then if you feel that you need to take out a certain amount of money, then reduce it for everyone.

But first get it fair, and that is what we have tried to give you—the fair part.

Mr. LEVIN. Thank you.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Welcome.

As usual your testimony is excellent and well-received by the committee.

Would it be fair for me to say that what you are saying is that the problems that hospitals face today are not problems of revenue but problems of costs?

Mr. ALTMAN. Yes.

Mr. DONNELLY. And that costs are increasing about 10 percent a year?

How many hospitals closed last year? Do you know?

Mr. ALTMAN. The number that has become sort of a part of the popular images—81. Recently I have heard that reflections suggest that it is less than that. But let us use 81.

Mr. DONNELLY. Yes, I also have statistics that dispute the 81 figure.

According to CBO, in the next fiscal year approximately 69 percent of the total overall Medicare payments will go for the treatment of illness, and about 31 percent will go for what I would call "ancillary passthroughs to institutions" in payments such as capital, direct and indirect medical education and direct disproportionate share.

Is that percentage—has that percentage been fairly consistent since the program was instituted in 1965? Do you know?

Mr. ALTMAN. 1965? You mean going all the way back to the beginning?

Mr. DONNELLY. Well, let us just say over the last decade.

Mr. ALTMAN. Well, first of all I think these are arbitrary lines, and quite frankly do not mean anything. I mean it is just how we choose what spigot we are flowing those dollars out of. It is all fungible money. We put them into little boxes and think we know what we are talking about, of which we do not.

Hospitals—we send it for capital and they turn out and buy things with it that is not capital. A lot of hospitals do not fund their depreciation.

Mr. DONNELLY. How do you justify the Medicare program spending $3.5 billion in the next fiscal year for the training and the cost of training for physicians and nurses? I mean is it the programs responsibility to pay that $3.5 billion?

Mr. ALTMAN. I think in the broader sense it is, yes. Whether the exact amount of money is right I am not saying.

I think Medicare is too big a part of the system not to respect its impact on the total system. And if we do not have—maybe a better way to do it——

Mr. DONNELLY. Have you ever looked at what share other segments of the population are paying for those costs?

Mr. ALTMAN. Well, not in detail, but by and large the Medicare program picks up its share of the total cost in proportion to the share in the hospital's budget.

Now, we have chosen to do it. Other countries do not do it that way. They fund their medical education systems out of direct appropriation. And there may be a very good case to make of the way we fund medical education, but as long as we are going to fund it heavily through our sick fund, if you will, or a delivery system, then I think Medicare should pay its portion; yes.

Mr. DONNELLY. Well, what other health care insurance system in the country has that sort of payment system?

Mr. ALTMAN. Well, I think commercial insurance companies—they pay charges, they pay a rate and built into those rates——

Mr. DONNELLY. But it is built into the rates, too?

Mr. ALTMAN. Yes.

Mr. DONNELLY. It is built into the rate as it would be their contribution to capital——

Mr. ALTMAN. Right.

Mr. DONNELLY. Would be built into the rate?

Mr. ALTMAN. That is right.

Mr. DONNELLY. Only the Medicare system makes direct specific appropriations for the training and the cost of training of the physicians, and the expansion or renovation of hospitals. Is that not correct?

Mr. ALTMAN. Yes. But again, as I said——

Mr. DONNELLY. Is that an efficient way to do it since 30 percent of the pie—or 31 percent in the next fiscal year is being spent of these direct subsidies in a very unique system?

Mr. ALTMAN. I think the decision that was made by the drafters of the legislation was that there are certain aspects of the costs system that they did not want to average out. And I can see the reason why.

It is very unevenly distributed. If you took all of the money that we now spend from medical education and threw it into the DRG payment system, averaged it out and then put it back out there you would find some hospitals that do almost no medical education would have a tremendous bonanza, and others would wind up on their knees.

So I did not draft it this way but I understand why they did it that way that is, they said that part of the total cost of education in the system should not be distributed evenly. And quite frankly there is some appeal to that. There is a lot of appeal to that.

Mr. DONNELLY. Now, is your recommended update for PPS excluded hospitals?

Mr. ALTMAN. The excluded? It is—on pages 9 and 10. It is 6.3 for pediatric, and 6.2 for the others. And again that is based on a combination of the market basket, and a correction factor. We built in in the beginning of our estimates what we call the correction factor. If last year we assume the market basket is going to be 4.5 and it turns out to be 5.2, we believe the system owes the hospitals that money. That is why the total is above market basket.

Mr. DONNELLY. What is the justification for excluding psychiatric hospitals from PPS?

Mr. ALTMAN. The justification has been that the illness included in psychiatric hospitals are very difficult to put into categories that can be measured appropriately by DRG. There has been a lot of work done by analysts to try to create psychiatric DRG's, and they exist. Some people believe that they are adequate. There is a lot of controversy about them.

Quite frankly one of the reasons why there is so much controversy is that the protocols for treating psychiatric patients are not as clear as they seem to be for nonpsychiatric. Some people feel they are motivated as much by the reimbursement system as they are by the medical treatment system.

Mr. DONNELLY. As you know I have been advocating linking the capital passthrough to some sort of occupancy rate test. I understand that ProPAC has some concerns about that. Could you enlighten me what your problems are with it?

Mr. ALTMAN. Well, we were talking with Mr. Gradison about this. The current system is turning out to be very tough on low occupancy. It is the toughest system you could design in terms of low occupancy.

It says to a hospital:

> If you lose a patient you lose all of the revenues that flow from that patient, likewise if you gain a patient you get all of the revenues.

We know that the marginal costs of treat an average patient is much lower than the average patient. But we get more when we treat more. Likewise if we treat one less patient a hospital cannot reduce the cost proportionately.

So this is a very tough system against low occupancy. And quite frankly, quite tougher than our certificate of need systems of the 1970's. The market is very impersonal. The other one is very political. And to impose a political system on top of a market system—not only does it seem redundant, but actually it would mess it up.

Now if you want to end the market system—which is what PPS is now doing—and introduce a political system, there is a case to be made for it.

But my feeling is that this system already penalizes low occupancy, and you do not need another add-on to that.

Mr. **Donnelly**. You do not think that the present system encourages overbuilding?

Mr. **Altman**. Quite the opposite. Those hospitals—one of the reasons why we are having troubles with cost is that a lot of hospitals chose to grow out of their problem rather than cut back, and they are finding that these growth-oriented strategies are not being matched by revenues. So, over time, this system will not—does not—encourage overbuilding. I think there was a temporary attempt to do that, and there is now a reassessment on part of the industry.

I do not know how a system like this encourages overbuilding because it basically says that "if you do not have a patient we are not sending you any money."

Unlike the old cost base reimbursement system, which was very inflationary and did encourage overbuilding.

Mr. **Donnelly**. Well let me just state, Stu—I have a thousand other questions, but we will have an opportunity hopefully to do it in Boston, and my time has expired but I would like to state for the record that as the committee is aware that it is projected that both the costs for capital and the costs—the dollar cost for the indirect medical education adjustment are projected to increase over 100 percent over the course of the next 5 years.

Mr. **Altman**. Yes.

Mr. **Donnelly**. I really think that this committee has a fiduciary responsibility to the Medicare beneficiaries and the taxpayers ought to take a close hard look at what the mission of Medicare is when we continue to have a funding mechanism for Medicare that is insufficient today and will be insufficient in the future to provide the services that are going to be demanded by an increasing client base.

Having said that I will leave it at that and visit with you in Boston.

Thanks so much.

Mr. **Altman**. Thank you.

Chairman **Stark**. Mr. Chandler.

Mr. **Chandler**. Thank you, Mr. Chairman.

Dr. Altman, I apologize for having to leave during part of your testimony. I had some constituents here, so perhaps you discussed what I want to ask about.

I recall when I met with hospitals at home that their feelings were more global than just the Medicare problem, and especially related to Medicaid reimbursement.

Mr. ALTMAN. Yes.

Mr. CHANDLER. I am concerned that we are ignoring that Medicare is one of only many payers. The discussion here tends to focus only on Medicare.

Is it your feeling that it is taking an unwarranted black eye for other problems?

Mr. ALTMAN. I do. Well, without moralizing, the idea that 37 million Americans have no insurance and many of them wind up in hospitals, and these hospitals treat these people, and then they go around to try and find the money, and one of the places where they try to find the money is from the Medicare program.

As I indicated before, increasingly they are trying to find money from our corporations. That is wrong, and often Medicare—as I have said—has been a relatively deep pocket. Hospitals have counted on that to balance out these underpayments from other payers.

Now, what is right and what is wrong is a tricky business. You could say "look, our job is to run the Medicare program. Our job is to make that system work." It is not our responsibility to worry about that. My own view is that that is wrong.

Medicare cannot afford to ignore the implications of the total system. Medicare can wind up doing fine and you will not have hospitals there. So we try in our calculations to look primarily at Medicare, but every once in a while we look beyond Medicare as we did with the teaching hospitals. When you look at PPS margins in the teaching hospitals it looks like they are raking in the money. But when you look at the total margins, our biggest teaching hospitals flip from having high margins to low margins and negatives.

So I think where you are heading is, I think, where we are heading.

Mr. CHANDLER. I thought our colleague Mr. Dorgan from North Dakota, was helpful in his testimony this morning. Certainly the State of Washington has some similar situations. Forks comes to mind. Most people have never heard of Forks. It is located out on the Olympic Peninsula on the west side of the State, and it is a remote area, a logging community and not much else. They have a little hospital over there which is just struggling to stay in existence. I do not know how many emergency cases they have a day, but lots and lots of broken limbs and other injuries result from that logging and sawmill kind of operation.

Yet my hunch would be, especially with the elderly, that if it is a more sophisticated procedure that business goes to Tacoma or Seattle or Olympia, or some place in which they have greater confidence.

It also reminds me that when I was a State legislator, we had a term for schools that were out in remote rural areas. The formula for funding that worked well for anything from a medium-sized community and up, just simply did not work because when students showed up at the doors, each represented $2,100 or whatever it was per student for the following year. If there were three students, which was the case on the San Juan Island School District, that obviously did not work very well. You could not hire a janitor for that.

We called them remote and necessary schools, and just made the conscious decision. We do not want those kids to have to go on a bus for 50 miles. We will pay the extra costs.

I was wondering—in spite of your objections to the idea of some mechanism to keep some hospitals open in those remote areas—if that does not beg for some kind of a designation for them, perhaps like that remote and necessary analogy to the school.

Mr. ALTMAN. I support that personally. I do not think you can use the reimbursement system, per patient, to do that. I think you need to establish a separate fund for remote and necessary. It perhaps ought to be shared between the Federal Government, the State government and the local community.

But I think you cannot possibly ask for a per patient payment system to be so distorted to count for that. But I personally have a problem believing that some of those institutions—for just the reasons that you stated—should stay open all of the time in our system. And I think that is the way we should handle it.

Mr. CHANDLER. Back to my initial question about the various payers, we cannot make that decision in isolation in this committee focusing on Medicare.

Mr. ALTMAN. That is it exactly. My own sense is from looking at the numbers that in order for these institutions to stay open we are going to have to pay much more than their costs, Medicare costs.

Mr. CHANDLER. Right.

Mr. ALTMAN. And the question is at what point is it inappropriate for the Medicare trust fund to be that, and I believe that it may need to go part of the way, but it might be appropriate to add general revenues, State revenues, local revenues—some combination.

But I think to use the Medicare payment system to do that will distort it too much—and even then it will not be enough.

Mr. CHANDLER. I have one more question, if I may, and that concerns the point of upcoding and whether you have seen evidence that legitimate upcoding exists? If you could comment on that?

Mr. ALTMAN. Well, there is no question that the case mix index has grown very sizably since the introduction of PPS. We have tried every way we can to estimate what part of that increase is legitimate, and our estimates are, they run between 50 and 75 percent legitimate, but there is definitely a component of that increase which is due to, what you euphemistically called, more sophisticated coding.

Mr. CHANDLER. All right.

Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson, did you have further inquiries for the witness?

Mrs. JOHNSON. Thank you. It was the coding question that I wanted to be sure and raise, concerning when you said, "euphemistically more sophisticated coding." We set the codes at the Federal level, and the theoretical structure within which we are functioning is if you fall within this DRG, we say, on average, it should cost a hospital this amount to care for you.

Well, if hospitals are more precisely identifying their patients as we refine the system, why should we now step back and say, "Because this person fits in that category, we should not be paying you that amount." I understand there is some gray area——

Mr. ALTMAN. Can I take a crack at it?

Mrs. JOHNSON. Yes, take a crack at it.

Mr. ALTMAN. We took the total pot of money that existed in 1981, and we projected it forward to 1984, and we divided it up into these 467 categories. We did not leave any—that is it—and we said, "OK, we are going to send the same amount of money we would have sent to you under the old system, but now we are going to send it to you under the new system."

We figured that on average these weights should equal one.

Mrs. JOHNSON. Correct.

Mr. ALTMAN. To the extent that it equals more than one, the system wound up sending to these hospitals more than we would have sent under the old system.

So it is not that we are not trying to pay them right. We wound up over paying, based on the fact that the upcoding—I am not talking about it being illegal. We had an imprecise way of putting these categories together, and the hospitals have educated us over the years on a better method.

All we are suggesting is not to penalize them, but to get the total back to where it belongs. So that is what——

Mrs. JOHNSON. Can we stop there just a minute?

In other words, what you are doing is, within a budget neutral setting—I think this is a very important point—you are now shifting reimbursements on a relative basis, not on a cost basis.

So you are saying that we now have to reimburse more richly for these and, therefore, less richly for these, in order to stay budget neutral?

Mr. ALTMAN. No. That is one thing. What I am saying is that in any year the system says that we are going to give you an update factor of say 5 percent, and we are going to give something else, and then the Government estimates how much is going to flow out.

Now, if the coding goes above that amount, more flows out then what was expected. To the extent that more is justified by sicker patients, it should go out——

Mrs. JOHNSON. Right.

Mr. ALTMAN [continuing]. To the extent that it is justified by more sophisticated coding, there is no basis in cost for that, and that is what we are trying to——

Mrs. JOHNSON. And what you are saying is that there is a certain amount of the coding that is not legitimate on the basis of sickness?

Mr. ALTMAN. Right.

Mrs. JOHNSON. And the system assumes that if you meet the criteria, you are, in fact, that sick and should get that reimbursement. I would say to you that I want more evidence that the upcoding is not legitimate, because what I see is that your decision is being controlled by the allegiance to budget neutrality.

So as you shift reimbursements into the higher—the sicker categories—you have shifted away from the cost of care for the less sick patient.

Mr. ALTMAN. Excuse me. It has nothing to do with budget neutrality.

Again, by the way, our estimates are as liberal as any that I have seen. There are other segments of this town that have defined portion due to sicker patients much lower. What we look at are surveys that are done after the fact by people going in and auditing the claims trying to determine whether people are legitimately sicker.

In our calculations, we not only give hospitals credit for legitimate increases in the codes that are treating sicker patients, but, also, we estimate what part of the patient mix has shifted from the low end within the DRG to a higher end, and still we come out with estimates, as I said in the 60 to 70 percent, that are legitimate for sicker patients, so we have taken away——

Let us see. Of the three percent last year, we took away 0.7 or less than a third. The alternatives are either you say "Whatever the coding increases are they are", or you say as some people say, "We are not giving any increases for coding changes."

Mrs. JOHNSON. Lastly, one reason I think that this is a very important issue——

Mr. ALTMAN. It is very important.

Mrs. JOHNSON [continuing]. Is that I think it does bear on the urban/rural problem. What I am finding in my hospitals is that in order to save money as they shift those more complicated operations to other more sophisticated hospitals—and you pointed out earlier that that is a cost effective thing to do—then they are left with the less sick patients who fall into DRG categories with lower reimbursements. Yet they have to distribute that the same capital facility cost over those DRGs.

So with a balanced case mix across all hospitals, a rural hospital can survive. But without a balanced case mix—and what some hospitals are saying that there is a greater imbalance in case mix across hospitals than in the past to save money—a rural hospital ends up being disadvantaged.

So my hospitals can say, "Yes, you promised us increases and reimbursements. Our experience is that we are having a decrease in reimbursements per patient."

Mr. ALTMAN. Yes, that is exactly what is happening.

Mrs. JOHNSON. And that is part of the reason why we see hospitals——

Mr. ALTMAN. And that is why some hospitals have been disproportionately hurt by the system. On the other, some have really made it as all these—you are right——

Mrs. JOHNSON. Thank you.

Chairman STARK. And then, doesn't it follow if the system is going to work, there has got to be some losers and some winners? If you just say, "You have to redesign the system to make all winners," you might as well go back to——

Mr. ALTMAN. In the simple world, you have sort of three choices.

Cost base reimbursement systems had a lot of advantages. It basically was institution by institution, it was patient by patient, everything was completely flexible—I call it the silly-putty system. It sort of mapped our delivery system perfectly, and that is what existed.

Once you move away from that, no matter how well you average, you are going to have winners and losers. If you are going to have big averages, you could go to total global budgeting.

You say to a hospital—other countries, that is what they do—they say, "Here is your budget for next year, 3 percent higher." "I have sicker patients." "Well, do the best you can." That is what we do with our school districts.

So that is the alternative. We can go back to a cost base system. We can play the game, which I believe is a decent game, and I do not want to degrade it by calling it a game. We can develop averages, try to do the best we can to make them fair, constantly adjust them, which is what PPS is all about, or we can go to some kind of a budgeting system, either by hospital or by country.

Chairman STARK. If we go to the budgeting system in cost reimbursement, we do not need hospital managers, right? We let ProPAC run the system. [Laughter.]

Mr. ALTMAN. My doctor here tells me I should say, "No." [Laughter.]

Chairman STARK. Thank you very much, Stuart, for, as usual, your enlightening and very helpful testimony. We will look forward to working with you in the months ahead.

Mr. ALTMAN. Well, Mr. Chairman, I can say this for myself and my fellow Commissioners, it is hard work, but our relationship with your committee sort of makes it worth it.

Thank you very much.

Chairman STARK. Thank you very much.

Our next panel consists of Richard Berman who is a special consultant with the firm of McKinsey & Co. in New York and Allen Dobson who is a principal in the Consolidated Consulting Group.

The lights that will flash for the members and witnesses for the remainder of the program are there to remind mostly the longer winded members, led by myself, that we would like to finish today and give everybody a chance.

The witnesses should be advised that their prepared remarks will be in the record in their entirety. We will sort of try and get you into a 10 minute mode, if we can, with the assurance that during the inquiry period, you can develop further in your testimony, and we will certainly stay with you as long as the members have questions remaining.

Having said that, I would ask Mr. Berman to start off and welcome you both to the committee.

Mr. Berman, you may start in any way you would like.

STATEMENT OF RICHARD A. BERMAN, SPECIAL CONSULTANT, McKINSEY & CO., INC., NEW YORK, NY

Mr. BERMAN. Thank you, Mr. Chairman and distinguished members of the Health Subcommittee.

I am pleased to be here today. I ought to, before my colleagues at the firm which employs me write you, clearly declare that these are my own opinions and my own views and do not represent their views necessarily.

What I will try to do, and I have given the members a smaller packet of charts so that I could go through it quicker, and at the same time in a little bit more detail.

But I think that part of the problem and part of the difficulty that you have had and that we all have had, trying to assess the fiscal health of the provider industry or classes of provider, whether they are urban or rural, a hundred bed, two hundred bed, public or private, for profit or not-for-profit, is that we keep looking at these national averages. I would suggest to you that they are the wrong gauges. They are not terribly helpful, and they do not reflect either the real market or the real patterns of delivering health care.

I would like to offer an approach that I would describe as more equitable to the beneficiaries, to all the providers, and to the taxpayers. It is basically built on fundamental economics, and that limits Government's role to setting a price and does not get us back to "spend as you can" or to individual microbudget regulation.

It is one that I think will increase the value of the Medicare expenditures and, at the same time, make sustainable and substantial changes to the hospital industry while leaving in place a viable industry to take care of the Medicare beneficiaries.

It is one that is based on two fundamental principles: It must be local market specific, and it is one which sets the price for that local market at a level of the local marginal supplier.

Let me just try to develop that quickly, my remaining 6 minutes.

It is based on the premise, and I think the fact, that health care is a local market product. It is not a national. It is not based on classes of institutions. Health care is made in local markets.

There are few economies of scale for producing in other markets, and I think we have learned that now, and some of our national hospital companies have learned that expensive lesson.

It is made differently in different local markets. Each local market has a different power balance among the various health care stake holders, whether they are patients or physicians, hospitals, employers, employees, or government, and it is neither exported nor imported beyond that market except for very small exceptions.

If you turn to and take a look at page 8 in the original testimony or exhibit 2 in your new packet, it is just another example of wide variation in local market performance.

You can examine returns on assets, you can examine returns on investments, profit margins, but there is clearly in almost every single market a huge variation. Therefore, if you want to make substantial and sustainable changes, and you want to deal with a industry that in many markets is over built, over supplied, one must again take a look at it locally.

There are a series of forces that explain why different suppliers, as in almost every other business that we have looked at, have different cost structures. Some of those are controllable. More quickly, in the short term. We define those as executional, and those deal with management, efficiency, asset turns, and productivity. Others have to do with structural differences, geographically where they are located, the structure of the bed units, that define how many nurses per bed that are necessary, et cetera.

I want to talk a little bit about how a local market price structured approach might work, and if you look at exhibit 4 or for those of you with the old packets, page 12.

Exhibit 4 identifies, basically, across the page, six different suppliers. Think of them as hospitals, and the height of the bars represent their average costs, and you can think of average costs per patient, or you can think of average costs per DRG—you can use almost any denominator that you would like. This is illustrative, but it is not uncommon in any industry whether it is automobile parts, manufacturing, police schools, et cetera, to see six legitimately different cost structures.

As you go to the next exhibit, which would be exhibit 5, you will see that in a market situation, if demand were there for the capacity that could be produced by the first four plants, the price that would finally be adopted would be where the dotted line referred to as the market price is drawn.

It would be that price that kept the marginal supplier fiscally viable, which would be manufacturer number 4 or hospital number 4 in this case, to viably produce that extra quantity. Not a price high enough to bring in company or hospital number 5, and not too low to drive out supplier number 4 which would result in hospital care not being available to some demand in that community.

Currently what we have with Medicare's national averaging is, in many communities, ended up with exhibit 6, which is a Medicare price below what is demanded, and therefore, we have some serious problems about long-term viability of necessary and desired hospitals, while in other cases, quite frankly, the Medicare price that is way above the demand and the supply that is required in any particular market.

That is why when you have an industry, where there is excess supply, you would expect, in fact, if the system worked well, that it would not keep those hospitals in business.

It would make for, a better—quality and be in the best of the Medicare beneficiaries to deal with that, to deal with it quickly, in order to take their limited resources and to focus them where they are needed.

My feeling is that it is important not only to look at the total dollars spent on behalf of Medicare beneficiaries, but also important to provide the right incentives, to maximize the value of the Medicare dollar. Medicare does drive much of the other parts of the health care system.

A requirement to help assure a viable hospital system of the proper size and shape in any local market, and whether that is a rural market, or whether that is an urban market.

If it is a remote, isolated institution serving a market, then you only have one institution, you have to be able to provide that capacity, and then, I think, you do have a responsibility to make sure that institution is viable.

In a market where there are more than one hospital in both rural and urban areas—because it is rural does not mean that there may not be an excess supply and more than one institution——

The same principles of setting a market price whereby the efficient supply is in fact met, will provide, I think, a more sensitive incentive resulting in a more tailored viable hospital system. You will then know that we are using our Medicare resources in a way that assure access for Medicare beneficiaries to the needed hospital or physician or outpatient care.

I think you cannot provide the right incentives, maximize the value of your expenditures, or help assure a viable hospital system of the proper size and shape, while setting policy based on national averaging.

The best way to leverage the fundamentals of the health care market is to drive off basic local market economics, and that is to set a reimbursement price for each local market, and that price level should be at the level that the local marginal supplier is finacially viable.

So you would examine supplier hospital number 4, and say, "Are there ways that you can, in fact, improve efficiency or effectiveness in order to reduce their price?" If so, you can lower the price. If not, then you cannot. Thank you.

[The statement of Mr. Berman follows:]

TESTIMONY OF RICHARD A. BERMAN TO SUBCOMMITEE ON HEALTH, COMMITTEE ON WAYS & MEANS, U.S. HOUSE OF REPRESENTATIVES, HEARING ON FISCAL YEAR 1990, BUDGET ISSUES RELATING TO HOSPITAL PAYMENT MARCH 1, 1989, WASHINGTON, D.C.

The views expressed are solely those of the author and do not represent the views or opinions of McKinsey & Company, Inc.

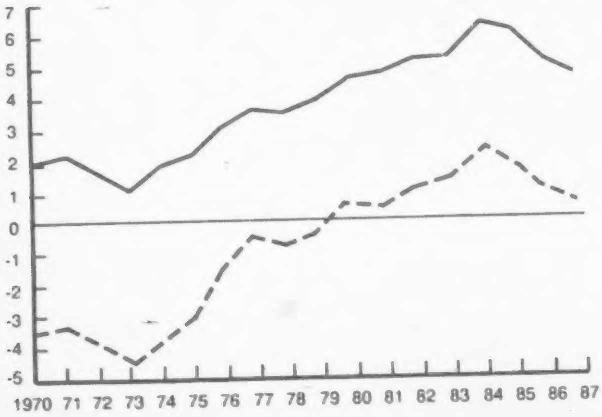
I am Richard A. Berman, Special Consultant, with McKinsey & Company, Inc.,an international management consulting firm. My remarks reflect my 20 years experience in government as a regulator, as a chief executive officer of a major teaching hospital as well as my recent experience working with payors, for profit providers, and pharmaceutical firms. The views and opinions expressed both in my written remarks and my oral testimony reflect my own personal views and in no way reflect the opinions of McKinsey & Company, Inc.

I believe that in order to maximize the value of the federal expenditures and at the same time to make sustainable and substantial improvements in our hospital system requires the adoption of a pricing/reimbursement approach which is:

- Local market specific
- Builds on the basic underlying economic theories of supply and demand.

Trying to assess the fiscal health of the provider industry from a national macro view can be frustrating and confusing if you are fundamentally looking at the wrong instrument guage.

HOSPITAL OPERATING MARGINS
1970-1987



Source: American Hospital Association National Hospital Panel Survey

The public policy that a single national price (even after adjusting for input prices) is the most equitable to beneficiaries, providers or to tax payers is without an economic base because:

- Health care is local market specific - it is not a national product, and there is not national health market.
- A local market micro analysis provides the best data to make substantial and sustainable improvements.
- Understanding the underlying economics of both the health care market and traditional market place economics is essential for developing and implementing an effective pricing/reimbursement attack.

Health care is a local market product.

- It is made in a local market - few economies of scale for providers outside of a given local market.
- It is made differently in different local markets.
- Each local market has a different power balance.
- It is neither exported nor imported beyond the market - people seek to get well close to home.

It is made differently in local markets.

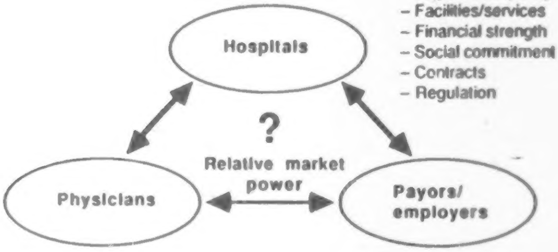
VARIATION IN MEDICAL CARE USE

Utilization measures	Low	High
- Hospital discharges/10,000 pop.	1,000	3,000
- Surgical procedures/10,000 pop. (general public) elective surgery	170	600
- Rates of carotid endarterectomy per 10,000 elderly persons	6	23

Source: Small area analysis, Paul-Shaheen, Journal of Health Politics, Public Policy & Law, Vol. 12, No. 4 Winter 87
Winslow, New England Journal of Medicine, Vol. 318, No. 12, March 1988

Each local market has a different power balance. Understanding the concentration and power balance is critical to assessing the potential impact of pricing or other regulatory actions.

RELATIVE MARKET POWER FRAMEWORK



Hospitals:
- Supply
- Location
- Reputation/quality
- Facilities/services
- Financial strength
- Social commitment
- Contracts
- Regulation

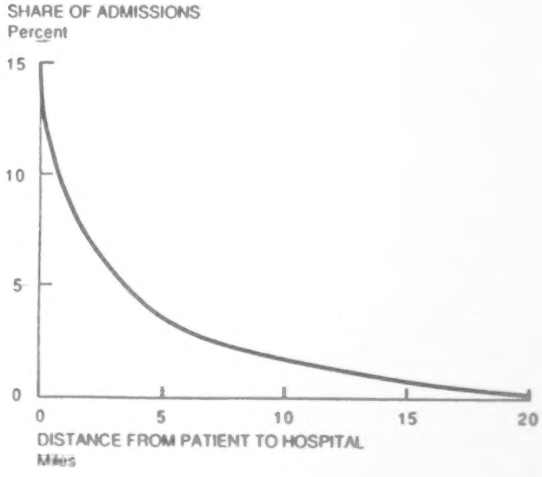
Physicians:
- Supply
- Reputation/quality
- Patient base
- Practice
- Contracts
- Organization

Payors/employers:
- Government policies
- Managed care
- Patient control
- Employer sizes and concentration
- Employer preferences/needs/attitudes

HEALTH CARE IS
A LOCAL BUSINESS

It is neither exported nor imported beyond the market - people seek to get well close to home.

HEALTH CARE IS A LOCAL/REGIONAL BUSINESS
Market share vs. distance -
major metropolitan market



A local market micro analysis begins to provide the data necessary to make substantial and sustainable improvement in the performance of the hospital delivery system.

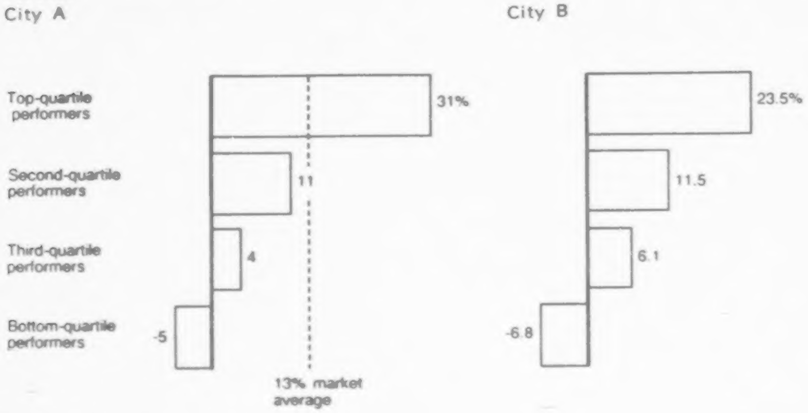
¶ There is great variation in the average ROI even in two similar cities.

¶ There is even a wider variation in ROI within each of these markets.

¶ ¶Even in this example, there are possible explanations that would suggest that the current level of reimbursement is too high too low.

There is even a wider provider performance variation within each local market.

PERFORMANCE VARIATION IN A MAJOR
METROPOLITAN HOSPITAL MARKET
Return on assets - 1986
Percent



Source: Medicare cost reports

Variations occur not only from differing financial objectives, but also from differing degrees of success in finding winning strategies and executing. Even in this example, there are possible explanations that would suggest that the current level of reimbursement is too high or too low.

ILLUSTRATIVE

Too high	Too low
- Bottom quartile is excessive and not efficient	- Not enough capacity
- All hospitals are inefficient	- Hospitals are wider capitalized
- Demand/utilization to high	- Hospitals are not treating sick

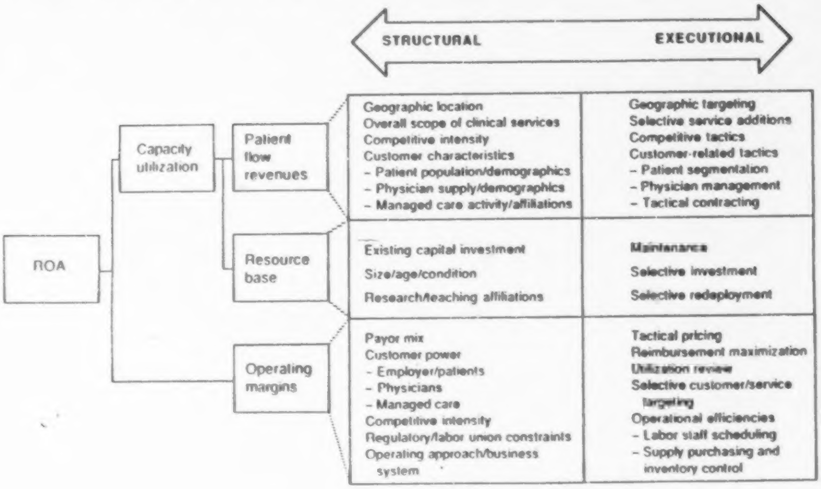
UNDERLYING ECONOMICS

¶ Hospital ROA is driven by both structural and operational elements.

¶ In the market place, price is set at a level that supply and demand meet and equal to production costs of the marginal supplier. The current Medicare reimbursement system is not responsive to the local market reality.

There are some fundamental reasons why two hospitals in the same markets may have inherently different cost structures. Some of these are due to structural factors while others are directly related to executional skills.

STRUCTURAL AND EXECUTIONAL
FACTORS INFLUENCING ROA

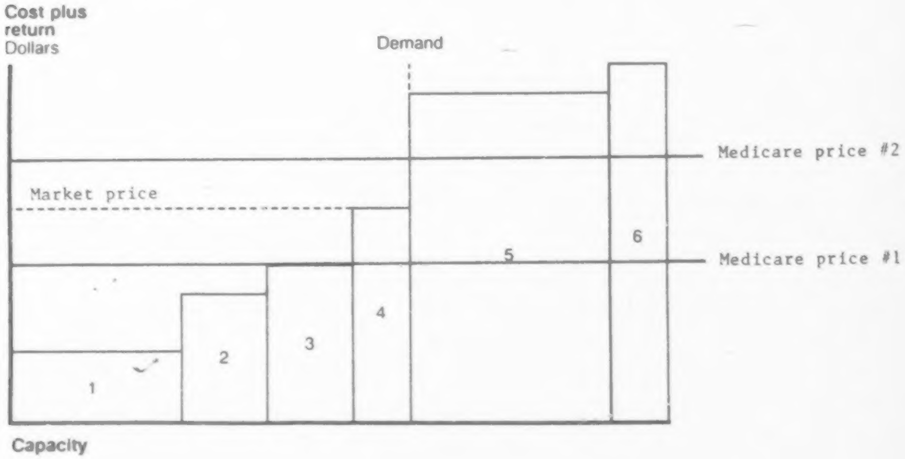


	STRUCTURAL	EXECUTIONAL
Patient flow revenues	Geographic location Overall scope of clinical services Competitive intensity Customer characteristics - Patient population/demographics - Physician supply/demographics - Managed care activity/affiliations	Geographic targeting Selective service additions Competitive tactics Customer-related tactics - Patient segmentation - Physician management - Tactical contracting
Resource base	Existing capital investment Size/age/condition Research/teaching affiliations	Maintenance Selective investment Selective redeployment
Operating margins	Payor mix Customer power - Employer/patients - Physicians - Managed care Competitive intensity Regulatory/labor union constraints Operating approach/business system	Tactical pricing Reimbursement maximization Utilization review Selective customer/service targeting Operational efficiencies - Labor staff scheduling - Supply purchasing and inventory control

In the market place, price is set at a level that the supply and demand lines meet and at a level equal to the production costs of the marginal supplier. In any given market, the current Medicare price could be too high or too low because it reflects a national average rather than local market reality.

SUPPLY AND DEMAND
DETERMINE PRICE

ILLUSTRATIVE



Chairman STARK. It is only fair that I should note that Mr. Berman was formally the director of the New York State Office of Health Systems, basically the State's hospital regulatory agency, and in those days, rate center, I suspect.

Our next witness, Dr. Dobson, was the former Research Director at HCFA and has now changed his hat as a consultant with Consolidated Consulting Group, and both of these gentlemen bring a wealth of experience to the committee.

We will now hear from Dr. Dobson.

STATEMENT OF ALLEN DOBSON, PH.D., PRINCIPAL, CONSOLIDATED CONSULTING GROUP

Mr. DOBSON. Thank you, Mr. Chairman.

I appreciate your invitation to testify this morning as an independent witness on the subject of hospital margins under the Medicare Prospective Payment System (PPS).

Today I would like to present several items.

First, I would like to talk about the assumptions underlying my work. Second, I will take a look at the trends in margins since the PPS was implemented. Third, I will discuss factors underlying these trends in terms of the distribution of hospital margins around averages. Next, I will indicate what happened to States with high or low hospital costs when PPS started, vis-a-vis evaluating State level trends as PPS has been put in place. I will also note how cumulative increases in Medicare costs have compared to cumulative changes in case revenues since PPS was initiated. Finally I will speculate just briefly on why Medicare hospital costs are rising faster than Medicare revenues.

In terms of assumptions, I have built a margin projection model over the past 2 years. I use a data base with 5,000 hospitals. The definition of operating margin that I use is Medicare operating revenues, minus Medicare operating revenues. There are no capital on direct medical expenditures included in my data. The information that I am about to present to you relates only to Medicare payments.

Another thing is that I make no assumptions about hospital behavior. I assume that hospitals will act through the latter part of the PPS implementation period as they had during the earlier part of PPS implementation for which we have data.

My Medicare revenue projections are based on the Medicare PPS payment rules, except for PPS 7 where I use the fiscal year 1990 Reagan budget assumptions. That is the rate of increase is set to market basket at minus 1½ percent, the educational adjustment factor goes from 7.7 to 4.05 percent, and there is an adjustment for case mix of about minus one-half percent.

For case cost increase assumptions I assume approximately a 10-percent rate of increase per year. As we have heard this morning, these are roughly the numbers that other analysts are assuming.

If we could turn to the exhibits in my testimony, I will walk you through my charts. I will make the points which I have keyed to each of my major charts.

We will start with exhibit 1.

[Chairman Stark points to an exhibit.]

Mr. DOBSON. Exactly. Yes, indeed.

The first point I would like to make relates to the development of the model. You see on the bottom of exhibit 1 that I have listed PPS year 1 through 3, and then Federal fiscal years for 1987, 1988, 1989 and 1990. This indicates that I shift the time period of analysis from the first 3 years of PPS when I use actual PPS cost report data which overlaps a 2-year period to a Federal fiscal year when I make my estimates.

You will note that the trend line has a kink in it between PPS year 3 and fiscal year 1987. While this is a technical matter, I want you to be aware of it.

The second point I would like to make in terms of calibration is that my margin numbers for the first 3 years of PPS—roughly 15 percent for PPS years 1 and 2 and 9 percent for PPS year 3—are very close to the ProPAC numbers you have heard this morning. My PPS 4 number is higher than ProPAC's because of the shift from PPS year to Federal fiscal year that I noted above.

The third point I would like to make reflects what we have heard this morning, that is, there has been increased financial pressure on the hospital industry as PPS has been phased in. By the time we get to year 7—fiscal year 1990—my estimate suggests a minus 7.2 percent Medicare operating margin for the hospital industry under current law, and a minus 11.5 percent for the industry under the fiscal year 1990 Reagan budget assumptions.

On exhibit 2, there are a lot of numbers, but I would like to make four relatively simple points. I think these points all go to the discussion we have had this morning as to whether or not PPS has been an effective instrument of public policy. I believe it has.

The first point I have just mentioned. We put PPS in place to put financial pressure on hospitals. If my numbers are even remotely correct, we have certainly done that, and we have done it in spades.

Second, early on in the program—that would be point 1 on the handout—we had a big difference between the urban and rural Medicare operating margins. For PPS year 1, I have circled 16.3 percent for urban hospitals and an 8.4 percent for rural hospitals. This discrepancy has been raised in testimony before you many times, and you yourselves have deliberately taken several legislative actions to equalize the margins between urban and rural hospitals.

You will note that by PPS 7, that I have a minus 11.5 percent for urbans and a minus 12.2 percent for rurals. These figures are obviously very much closer together.

The work that you have done thus has been very effective in equalizing the difference in margins between urban and rural hospitals under PPS.

The third point—number 2 on the exhibit—I would like to make in terms of my chart goes very much to what Mr. Berman has said. That is, if you look at regions of the country, what has happened under PPS is that we are getting a spread—a spread as we move through time between the lowest and highest margins across the regions from PPS 1 to PPS 7.

For instance, I calculate for PPS year 1 a difference between highest and lowest regional margins of 5.7 points.

By the time we get to PPS 7, I see a 16.7-percent spread between the highest region and the lowest region. From this we might conclude—extending the point Mr. Berman was just arguing—that we ought to take account of regional or local markets when we consider the future of PPS.

Another thing that we can see happening is my fourth point, No. 3 on the chart. We started out with teaching institutions having very much higher margins than nonteaching hospitals. If we assume implementation of the Federal fiscal year Reagan budget assumptions, conserving in direct medical education a minus 10.1 percent for teaching and a minus 12.7 percent for nonteaching might result. These results are very much closer than when PPS started where I estimate a 17.7 percent teaching margin for teaching hospitals, and roughly a 12.8 percent margin for nonteaching hospitals.

So I think the conclusions of this chart is that we have nearly equalized urban-rural margins, margins have spread out across regions, and we have done what we said we would do with teaching as we reduced the indirect teaching adjustment.

On exhibit 3, we observe the variation in margins across hospitals within a given PPS year. This exhibit contains percentiles. A median percentile indicates that half the hospitals do better and half the hospitals do worse than the number indicated. I have a minus 4.9 percent median estimate for PPS year 6; that is half the hospitals will do worse than minus 5 percent and half the hospitals will do better than a minus 5 percent operating margin.

If we look at the 90th percentile, this indicates that 10 percent of hospitals will do better than the number in the bracket—22.2 percent for PPS year 6.

This is a point we have heard this morning; that is, that over time about 10 percent of hospitals seem to do well under PPS—these could be different hospitals due to the effect of PPS transition rules.

On exhibit 4 I provide more detail for PPS year 7. The column to look at is the far right column. There I give PPS year 7 results by individual hospital category.

I would like to draw your attention to the urban greater than a million category, which is at 14 percent, the other urban category a minus 8.4 percent, and the aggregate rural, which is minus 12.2 percent.

The spread of those numbers is very consistent with the ProPAC recommendations that Congress give a bit more revenue to those hospitals that seem to be doing a little worse under PPS. My numbers and presumably the numbers calculated by ProPAC which led to their recommendation seem to be very much in line.

We can now turn to exhibit 5. Exhibit 5, on the far right column that I have bracketed with the number 1, provides my estimate of margins of the State level.

I make no pretense that my State estimates are entirely accurate. By the time you get down to State level estimates the precision of the model is not as good as one would like.

On the other hand, if we look at Alaska, California, and Washington margins—Alaska with a minus 28.3 percent margin, California with a minus 18.6 percent margin, and Washington, DC with a minus 24.9 percent margin—when you look behind these estimates what you see is that hospitals in these States had high initial cost structures when PPS was initiated. Across the States hospitals in high-cost States have not been able to decrease their costs enough to fully cushion themselves as we have moved to full national rates.

Chairman STARK. Excuse me, now.

Mr. DOBSON. Yes.

Chairman STARK. Is there any correlation in those numbers with occupancy by any chance?

Mr. DOBSON. I have not conducted those analyses, but my guess is——

Chairman STARK. Could you push a button or two on your Macintosh and get those for me?

Mr. DOBSON. That is something that could be done, yes.

Chairman STARK. I would appreciate it. Thanks.

[The following was subsequently received:]

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CCG **Consolidated Consulting Group**

April 18, 1989

The Honorable Fortney H. Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1114 Longworth House Office Building
Washington, D.C. 20515-6349

Dear Mr. Chairman:

Purpose

During your Subcommittee Hearing of March 1, 1989 you asked that I put together an analysis of how occupancy rates affect Medicare case costs. My staff and I have conducted a brief analysis of this issue. In particular, I asked two questions:

(1) "Do changes in occupancy rates over time (PPS Year 2 to PPS Year 3) influence the annual rate of change in Medicare case costs?" and

(2) Within a given year (PPS Year 3) "How do occupancy rates influence the level of Medicare case costs?"

That is, I wanted to determine the extent to which the rate of change in Medicare hospital case costs from one year to the next is affected by the corresponding rate of change in occupancy rates and alternatively, I wanted to determine if the level of Medicare hospital case costs across hospitals is affected by occupancy levels in these hospitals.

Methodology

I used information from the Medicare cost reports (MCR) for PPS Years 2 and 3. From this data I calculated the rate of change in Medicare costs per case from PPS Year 2 to PPS Year 3 for the 4282 hospitals for which I had data for both years. I also calculated the level of Medicare case costs for PPS Year 3 for 5003 hospitals. (When only one year of data was required, I have complete data for more hospitals.)

I then used one statistical model to link percent change in Medicare hospital case costs for each hospital to a series of "explanatory" variables, and another statistical model to link PPS Year 3 Medicare hospital case costs to a series of explanatory variables. The explanatory variables used included:

a) Occupancy rates (% change and level);

b) a Medicare case mix index (CMI) (% change and level);

c) Medicare days as a fraction of all hospital days (% change and level);

d) beds per hospital in PPS-3;

e) teaching payments as a percentage of Medicare payments in PPS-3;

f) outlier payments as a percentage of Medicare payments in PPS-3;

g) disproportionate share payments as a percentage of Medicare payments in PPS-3;

h) area wage index for 1987; and

i) an urban/rural indicator.

Rate of Change Findings

A key question underlying the debate in Medicare PPS payment policy is: "Why have Medicare hospital case costs been rising on the order of 10% per year since the introduction of Medicare PPS?" One possible explanation is changes in occupancy rates. Table 1 contains AHA occupancy rate data for 1985 and 1986 (as taken from, the June 1989 ProPAC report, p. 50), and our estimate of occupancy rates for PPS Year 2 and PPS Year 3 as derived from MCR data. (See Appendix A for detail of MCR estimates.)

Table 1
Hospital Industry Occupancy Rate Measures

	AHA (ProPAC)		MCR	
	Level	Change	Level	Change
1985 (PPS Year 2	63.6		59.7	
1986 (PPS Year 3)	63.4	-0.2	60.4	0.7

Both sets of estimates indicate that occupancy rates were relatively stable over this time period. However, because occupancy rates declined substantially during the early eighties and have changed differently one hospital to another, it is important to determine how sensitive rates of increase in costs are to changes in occupancy rates.

I found that for every 1 percentage point increase in the occupancy rate (from PPS-2 to PPS-3) Medicare costs per case fall by 0.18%. Using the occupancy rate estimates from Table 1, I found that the PPS-2 to PPS-3 change in occupancy rate accounted for either a 0.04% increase in costs (using the AHA - ProPAC numbers) or a 0.13% decrease in costs (using the MCR numbers). Given an overall cost increase of 10%, I conclude that changes in occupancy rates are not strongly related to the recent increases in Medicare hospital case costs.

The analysis showed that other factors had a more significant impact on the change in Medicare case costs. In particular, the percent change in the Medicare CMI, the percent change in Medicare days as a percent of all days and outlier payments as a percent of Medicare payments were all positively correlated to cost growth. The number of beds per hospital was negatively related to changes in costs. Other variables described above did not have a significant impact on the change in costs.

The analysis also showed that the effect of changes in occupancy rates on changes in costs was greater for smaller and more rural hospitals than for larger and more urban hospitals. For every one percentage point increase in occupancy rates for small hospitals (under 50 beds), Medicare costs per discharge would fall 0.61% (i.e., a little over three times the total hospital average). Conversely, the model showed that the change in cost for large hospitals due to the change in occupancy rates was not statistically significant. For rural hospitals, a one percentage point increase in the occupancy rate would reduce costs by 0.22%. For urban hospitals, the corresponding cost reduction would be 0.11%. These findings suggest that changes in volume pose more risk for the smaller hospital, especially those hospitals with less than 50 beds.

Level Findings

The above analysis indicates that the rate of change in occupancy rates from one year to the next is not a powerful explanatory factor of the 10% annual cost increases recently experienced by the hospital industry. Another question, however, is the degree to which differences in occupancy rate levels across hospitals within a given year can explain differences in case cost levels across hospitals.

Testing this question with our statistical model I found that a one percentage point increase in occupancy rates within a given year (PPS-3) was associated with a $7.24 reduction in cost per case, which is roughly a 0.2% decrease. That is, if hospitals increased their occupancy rate by 5-10%, case costs would decrease on the order of 1-2%. But, this would represent only a one time savings because occupancy rates cannot continue to increase indefinitely. Note as well that a rather dramatic change in occupancy rates still would not eradicate the ten percent per year case cost increases currently being experienced by the hospital industry.

In the level analysis, I also found that the Medicare case mix index, the wage index, teaching, outliers, disproportionate share cases, and bed size increased case costs, while Medicare days and rural location were associated with lower case costs.

As with the rate of change analysis, the level analysis found that small and rural hospitals are much more sensitive to differences in occupancy rates than are large and urban hospitals.

Discussion

I conclude that changes in the occupancy rate account for only a small proportion of the percent change in Medicare case costs. Other cost and utilization factors, such as the Medicare CMI and the Medicare fraction of days in each hospital, are more important indicators in explaining changes in Medicare case costs. Within a given year, I note that a ten percentage point increase in occupancy rates is associated with about a 2% decrease in Medicare case costs. That is, if the industry dramatically increased its occupancy rates, there might be a one time savings of about 2%. This savings, while important, would be difficult to achieve and would not influence year to year cost increases except in the year the occupancy rate increase occurred.

These findings are consistent with my understanding of the hospital cost function literature[1]. They suggest that the cost of an empty bed, especially if "mothballed", is relatively small. This seems reasonable given that capital costs are only about 7% of hospital costs. Wages, salaries, and supplies make up the bulk of hospital costs, and all of these expenses depend upon the actual workload the hospital faces. That is, the variable cost of a given hospital stay represents a relatively high proportion of the average case cost. This being the case it may be unrealistic to expect increases in occupancy rates to dramatically influence the cost structure of the hospital industry.

While I am relatively certain that the general direction of my findings is correct, the study I conducted was not extensive as it was conducted with limited resources and over a fairly short time frame. To this extent, I caution you to take these results as preliminary and indicative rather than in any way definitive.

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[1] For example, another study using early 1980's AHA data on all payers found that a one percentage point increase in occupancy rate led to a 0.23% decrease in cost per case, roughly what I found using Medicare Cost Report data. See Thorpe, K.E. "Why are Urban Hospital Costs so High?", *Health Services Research* v.22 (February 1988), pp. 821-835.

If you wish to discuss these findings please give me a call.

Sincerely,

Allen Dobson, Ph.D.

AD/afh

Enclosure

COMPARISON OF OCCUPANCY RATES FOR HOSPITAL GROUPS FROM PPS2 TO PPS3

STATE	OCCUPANCY PPS2	OCCUPANCY PPS3	CHANGE IN OCCUPANCY
ALABAMA	0.5368	0.5670	5.62
ALASKA	0.5595	0.4785	-14.48
ARIZONA	0.5968	0.6243	4.60
ARKANSAS	0.5406	0.5504	1.81
CALIFORNIA	0.5977	0.6106	2.16
COLORADO	0.5434	0.5578	2.66
CONNECTICUT	0.7046	0.6903	-2.02
DELAWARE	0.6869	0.7310	6.43
WASHINGTON D.C.	0.7855	0.8032	2.25
FLORIDA	0.6089	0.6003	-1.41
GEORGIA	0.5919	0.5874	-0.76
HAWAII	0.6848	0.7235	5.66
IDAHO	0.5004	0.4989	-0.31
ILLINOIS	0.5748	0.5929	3.15
INDIANA	0.5679	0.5694	0.28
IOWA	0.4701	0.4648	-1.13
KANSAS	0.4613	0.4653	0.86
KENTUCKY	0.6169	0.5876	-4.74
LOUISIANA	0.5620	0.5246	-6.67
MAINE	0.5794	0.6266	8.15
MARYLAND	0.6776	0.7252	7.02
MASSACHUSETTS	0.7121	0.6619	-7.06
MICHIGAN	0.6272	0.6160	-1.79
MINNESOTA	0.5170	0.5074	-1.86
MISSISSIPPI	0.5751	0.5574	-3.08
MISSOURI	0.5861	0.5874	0.21
MONTANA	0.4830	0.4770	-1.24
NEBRASKA	0.4664	0.4592	-1.54
NEVADA	0.4755	0.4986	4.86
NEW HAMPSHIRE	0.5957	0.6093	2.28
NEW JERSEY	0.7263	0.7592	4.52
NEW MEXICO	0.5506	0.5278	-4.14
NEW YORK	0.7933	0.7678	-3.21
NORTH CAROLINA	0.6128	0.6646	8.45
NORTH DAKOTA	0.5379	0.5292	-1.63
OHIO	0.5999	0.5978	-0.36
OKLAHOMA	0.5229	0.5239	0.20
OREGON	0.5163	0.4877	-5.54
PENNSYLVANIA	0.6689	0.6728	0.58
RHODE ISLAND	0.7410	0.7327	-1.11
SOUTH CAROLINA	0.6496	0.6571	1.15
SOUTH DAKOTA	0.4598	0.4607	0.19
TENNESSEE	0.5997	0.5899	-1.62
TEXAS	0.5225	0.5139	-1.64
UTAH	0.5499	0.5293	-3.75
VERMONT	0.5617	0.5699	1.45
VIRGINIA	0.6257	0.6364	1.72
WASHINGTON	0.5490	0.5505	0.27
WEST VIRGINIA	0.5677	0.5587	-1.58
WISCONSIN	0.5141	0.5164	0.46
WYOMING	0.4066	0.4116	1.21

COMPARISON OF OCCUPANCY RATES FOR HOSPITAL GROUPS FROM PPS2 TO PPS3

DESCRIPTION	OCCUPANCY PPS2	OCCUPANCY PPS3	PERCENT CHANGE IN OCCUPANCY
ALL HOSPITALS	0.5971	0.6040	1.15
URBAN			
AGGREGATE	0.6343	0.6431	1.39
< 100 BEDS	0.4712	0.4791	1.69
101-404 BEDS	0.6146	0.6171	0.41
405-684 BEDS	0.6890	0.7058	2.44
685+ BEDS	0.7045	0.7370	4.61
RURAL			
AGGREGATE	0.4824	0.4759	-1.35
< 100 BEDS	0.4067	0.3949	-2.90
100-169 BEDS	0.5022	0.4942	-1.59
170+	0.5782	0.5835	0.92
NEW ENGLAND	0.6900	0.6634	-3.86
MID ATLANTIC	0.7007	0.7295	4.11
SOUTH ATLANTIC	0.6197	0.6315	1.91
EAST NORTH CENTRAL	0.5859	0.5873	0.25
EAST SOUTH CENTRAL	0.5841	0.5754	-1.50
WEST NORTH CENTRAL	0.5216	0.5179	-0.71
WEST SOUTH CENTRAL	0.5327	0.5223	-1.95
MOUNTAIN	0.5434	0.5441	0.13
PACIFIC	0.5859	0.5981	2.09
MAJOR TEACHING	0.7504	0.7633	1.72
OTHER TEACHING	0.6665	0.6671	0.09
NON TEACHING	0.5543	0.5876	6.01
CHURCH	0.6287	0.6396	1.72
NOT-FOR-PROFIT	0.6215	0.6313	1.59
PROPRIETARY	0.5240	0.5150	-1.71
GOVERNMENT	0.5269	0.5382	2.15
DISPRO. SHARE		0.6893	
NOT-DISPRO SHARE		0.5993	

Mr. DOBSON. Now, a while back we wondered why some hospitals do better than others. You will note that I have estimated 10.1 percent PPS year 7 margins for New York. That is probably too high.

On the other hand, I note that New York has a high share of indirect medical adjustments, a high share of disproportion adjustments, a high share of outliers, and a relatively low-cost structure.

A while ago you asked Dr. Altman why some hospitals did better than others. In New York, at least we find that the factors Dr. Altman mentioned contains high margins in spades, I believe this is so, because the things that work within the PPS to cushion PPS financial impact seem to come together in New York for high margins.

Mr. BERMAN. Plus a higher occupancy.

Mr. DOBSON. Which we will check when we push the button on the Macintosh.

In exhibit 7, I provide distributional data around my PPS year 7 estimates. The only point I want to make here is that, if you look at urban hospitals where I have the minus 12.37 percent circled, I estimate that half the urban hospitals will do better than minus 12.4 percent, and half the urban hospitals will do less well.

And I note by the time you get to the 10th percentile—which means that 10 percent of the hospitals would do worse—I have a minus 50 percent. That could be a result of bad data, it could be a lot of things, but it does suggest that margins are pretty widely spread.

On exhibit 7, I provide percentiles for States. I have underlined California, not to pick on California, but rather to make the point that you find a great deal of spread around overall margin estimates. Here we see a median estimate of 17.9 percent—again this means that half the hospitals would do better, and half the hospitals would do worse—and a minus 61 percent or lower for the worst 10 percent of California hospitals.

Again, these low performing could reflect outlier data, but there probably are a few hospitals in California that will not do terribly well by PPS year 7.

Exhibit 8 is a very complicated table, but what I want to say about it is very simple. If States start hospitals with high initial hospital costs—that is a high hospital specific payment proportion under the prospective payment system—what tends to happen is that hospitals in these States typically will not be able to cut their costs enough to be profitable under a national PPS rate structure.

My estimate of PPS year 3 margins for these types of States indicate that they will do very poorly. That is, those States with hospitals that start with high initial costs do not do well under prospective payment.

Second, I have looked at the rate of increase of State average hospital costs between PPS year 1 and PPS year 3, that is the second column of exhibit 8, and what I find is that the hospitals that started with high costs at the State level have not necessarily been able to cut their costs better than those that had low costs.

I think that is a disturbing finding. Basically, it says there are some fundamental underlying reasons why costs are moving the way they are that seem to be pretty powerful, and resistant, at the

State level at least, to many of the kinds of incentives in prospective payment.

Exhibit 9, I have underlined two lines. The line titled TEFRA cumulative costs, the top line that says 72.3 percent, represents the total cumulative rate of increase in case costs that I estimate through the first 7 years of prospective payment.

The line below that, where I have TEFRA cumulative revenues, is my estimate of the cumulative rate of increase in case revenues through the end of year of the program.

As we have heard many times, at the very start of the program case revenues rose more rapidly than case costs. The increase between TEFRA and PPS-1, using ProPAC numbers, is 18.7 percent for case revenues, while case costs rose only 2.2 percent.

That is why we see the very high margins in the first few years of PPS.

On the other hand, if you look at the unshaded lines, the ones that I do not have bolded, what we see is that since the period PPS-1 to PPS-2, costs have risen uniformly faster than case revenues.

Why? I am not sure, but I think it is a pretty clear fact that that has been the case. The ProPAC testimony highlighted that as well.

It is sort of like, what have you done for me lately, in terms of how you look at the information in exhibit 9. That is why I present both sets of lines. You can get very different impressions of what is happening to the relative relationships of revenues and costs, depending on which base period you use.

My final exhibit lists a series of pressures for lower and higher hospital costs. I put this list together for Mrs. Johnson after the August 1 Budget Committee testimony. I have refined this list somewhat since then. I will just leave this list with you as speculation on why hospital costs have risen.

To conclude, there are many assumptions that underlie the very complex margin estimation models that I and ProPAC have built.

Given the 4 years of baseline cost data, and reasonable, I hope, revenue assumptions, it is pretty clear that we have put increasing financial pressure on hospitals through time. Hospital margin estimates vary widely across types of hospitals, and more importantly, or perhaps equally as important, across geographic areas. It is not clear to me that that resultant margin differences across geographic areas are due to efficiency. Practice pattern variation may be the culprit.

States with hospitals with high initial cost structures will probably not be able to protect themselves as we move into the seventh year of PPS.

Finally, there are apparently numerous reasons why hospital costs have risen. I do not think society or the industry has as yet actually determined what those reasons are. It is very hard to understand why hospital costs have gone up 10 percent a year, relative to the revenues, about 5 percent a year.

Thank you.

[The statement of Allen Dobson follows:]

ESTIMATING MEDICARE OPERATING MARGINS UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

WAYS AND MEANS HEALTH SUBCOMMITTEE

TESTIMONY OF ALLEN DOBSON, PH.D.

MARCH 1, 1989

OVERVIEW

I appreciate your invitation to testify this morning as an independent witness on the subject of hospital margins under the Medicare Prospective Payment System (PPS). I was the Research Director for the Health Care Financing Administration (HCFA) where I participated in the design, implementation and evaluation of Medicare PPS. I am currently a Principal with the Consolidated Consulting Group (CCG) -- a healthcare consulting firm located in Washington, D.C. Most of my work deals with hospital and physician payment issues for private sector clients.

Today I will present:

(1) A series of assumptions underlying projections of Medicare Operating Margins conducted by the Consolidated Consulting Group (CCG);

(2) General trends for National Medicare Operating Margins for PPS Years 1-7;

(3) Details of these trends in Medicare Operating Margins by winners and losers for PPS Years 1-7;

(4) A comparison of pre-PPS hospital relative payment levels, hospital cost increases, and Medicare Operating Margins at the state level;

(5) Statistics on the behavior of overall Medicare per case costs and revenue increases since the introduction of PPS; and

(6) Speculation on why hospital costs are rising faster than the hospital market basket.

Assumptions

To measure the financial pressure that PPS exerts on hospitals, I use the Medicare Operating Margin defined as: PPS operating revenues less PPS operating costs divided by PPS operating revenues ((R-C)/R). This definition is used by CBO, HCFA, OIG and ProPAC.

We develop Medicare Operating Margins, by calculating per case revenue and per case cost estimates at the hospital level. The estimating models generally in use do not make any assumptions about hospital behavior. That is, our projections assume that hospitals will continue to perform in the future pretty much as they have in the past. We now have enough experience with PPS that, generally speaking, this assumption should prove reasonable.

Revenue projections are based on either existing PPS payment rules as established by the Administration and Congress or as in the case of PPS Year 7, use FFY 1990 Reagan Budget assumptions. These are:

(1) Hospital market basket less 1.5 percent (MB - 5.85);

(2) A cut in the Indirect Medical Teaching Adjustment amount; and

(3) Technical corrections which adjust for changes in hospital case mix.

Revenue projections are also adjusted for case mix increases associated with coding changes as opposed to changes in patient severity. This is accomplished by increasing revenues relative to costs thus, increasing margin estimates.

Cost assumptions are more speculative. I use detailed Medicare Cost Report data from the first three years of PPS (referred to as PPS-1 to PPS-3 Medicare Cost Report Data) and overall trend information from preliminary PPS-4 cost report data. Recent cost information provided by the American Hospital Association (AHA) Panel survey suggests that, in aggregate, the resulting projected rates of cost increases of just under 10% per year are not unreasonable. To allow for the fact that individual hospitals exhibit very different rates of cost growth, I have blended industry-wide cost increase projections with hospital-specific cost increase projections.

A computer model that uses information from 5,000 hospitals was used to produce the results presented today.

Historical and Projected Trends

Exhibit 1 provides a trend line of Medicare Operating Margins. Estimates for the first three years are based on actual cost and revenue data taken directly from Medicare Cost Report files. These estimates represent hospital fiscal years (HFY) because PPS was phased-in by HFY. (Thus, any given PPS "year" overlaps nearly 2 calendar years.) Estimates for PPS Years 4 to 7 are by Federal fiscal year (FFY). My PPS-4 year estimates are higher than ProPAC's PPS-4 estimates because they represent a different accounting time period (i.e. PPS Year vs. FFY).

The trend in margins is clearly down, resulting in a margin of -7.2% under current law and -11.5% under the Reagan Budget assumptions for FFY 1990. Given the evidence, it seems safe to assume that as time passes, PPS is applying increasing financial pressure to the hospital industry.

Detailed Margins and Percentiles

Exhibit 2 contains PPS Medicare Operating Margin estimates by hospital group and Census Division for PPS Years 1 to 7. The precision of hospital group estimates is considerably less than that for the overall trend line. These data indicate how a given hospital group has fared through time. For instance: (1) The "fixes" Congress set in place for rural hospitals appear to have benefited rural hospitals; (2) the transition from blended rates which reflected some amount of each hospital's actual costs to full national prospective payment rates has moved regional margins further apart; and (3) the Reagan budget proposal to reduce the indirect teaching adjustment reduces the protection that teaching hospitals received under PPS during the early years.

Exhibit 3 shows the degree to which winner and loser hospitals exist for any given PPS year. For instance, in PPS Year 6 (FY 1989), the payment year we are currently in, half of the Nation's hospitals are projected to lose 4.9% or more (the median value) and 25% of the Nation's hospitals are projected to lose 21.3% or more (the 25th percentile). An interesting aspect of this table is that 10% of the Nation's hospitals (the 90th percentile) show high margins for each year of PPS implementation. Note that even in PPS Year 7, the top 10% of hospitals are earning 18.9%.

Exhibits 4 and 5 present detailed PPS Year 7 (FFY 1990) Medicare Operating Margin estimates by hospital group and by state. The exhibits indicate that Medicare Operating Margins vary considerably by hospital group, Census Division and state. As noted above, detailed estimates are not as accurate as overall estimates. This is especially true for the state-level estimates of small states contained in Exhibit 5. However, I am comfortable concluding that by PPS Year 7, that nearly all groups of hospitals will have a negative Medicare operating margin (see Exhibit 4) and that the impact of PPS will be highly uneven across states (Exhibit 5).

Exhibits 6 and 7 expand on this theme by providing detailed percentile information by hospital group and by state. Exhibit 6, for instance, indicates that by FY 1990, half of the Nation's urban hospitals could have a Medicare Operating Margin of less than -12.4 and 25% of the Nation's urban hospitals could have a Medicare Operating Margin of less than -28.3% under the FFY 1990 Reagan Budget assumptions. The conclusion to be drawn from these percentile estimates is that considerable variation will likely exist around a given hospital group's average operating margin during PPS Year 7. Exhibit 7 indicates that individual states will also have a wide range of winner and loser hospitals (see California for instance).

Hospital Specific Payment Rates, Hospital Cost Increases, and Medicare Operating Margins at the State Level

Exhibit 8 presents state-level data on the hospital-specific payment amounts used when PPS was initially phased-in (inflated to PPS Year 3 levels). The hospital-specific payment amounts reflect hospital's relative cost levels prior to PPS. Exhibit 8 also shows hospital annual compound rate of cost increases over the first three years of PPS and PPS Year 3 and PPS Year 7 margin estimates. This table ranks each variable from lowest to highest. All variables are case-weighted. The relationship of these variables is very informative. Using estimates of how well one set of variable rank orders relates to another variable's rank orders, the following is noted at the state level:

- Hospital-specific amounts are not well correlated with PPS Year 3 margins, but are highly negatively correlated with PPS Year 7 margins (this by far is the strongest finding);
- Hospital-specific amounts are not highly correlated to PPS-1 to PPS-3 cost increases;
- PPS-1 to PPS-3 cost increases are negatively correlated with PPS Year 3 and Year 7 margins; and
- PPS Year 3 margins and PPS Year 7 margins are highly correlated.

I conclude from these findings that hospitals in states with high average initial cost levels were not able to fully protect themselves through cost-cutting activities as PPS was phased-in.

Exhibit 8 data indicate that a PPS payment system based on full national rates may be an ineffective cost control system to the degree that it is ultimately perceived as inequitable in its results. That is, by the end of it's third year of operation, PPS had not been able to affect the fundamental cost structure of the industry across states. In retrospect, I'm not sure we knew enough about why hospital case costs vary at the state (hospital) level to justify the use of full national rates. While fine-tuning PPS with urban-rural equity provisions, a complex system of outlier payments and the like partially corrects for basic cost differences across geographic areas, the evidence suggests that total reliance on National Federal rates will lead to dramatically different financial results for the Nation's hospitals. I would note in passing that the financial incentives and savings of a prospective payment system could be achieved under a PPS that retained some amount of hospital-specific payment in its rate structure.

Underlying Cost and Revenue Behavior

Exhibit 9 indicates two views of the cumulative growth rates for cost and revenue variables in the context of PPS. One set of growth rates (the TEFRA rates) starts with the year before PPS and accumulates percent changes for a given variable to PPS Year 7. The other set of growth rates (the PPS rates) starts with the first year of PPS. As with Exhibit 1 margin estimates, the data for PPS-1 to PPS-3 are by PPS year and the data for PPS Year 4 and above are for FFY. The TEFRA cumulative growth rates indicate that PPS revenues were initially high relative to costs. PPS revenues per case increased 18.7 percent from the year before PPS (TEFRA) to PPS-1. This means that 35.7% of overall PPS cumulative revenue increases of 52.4% come very early in the program. Cost increases have been more evenly distributed over the years of PPS operation. By PPS Year 5 (FFY 1988), cumulative costs are close to cumulative revenues and by FFY 1989 cumulative costs are greater than cumulative revenues.

The PPS cumulative growth rates indicate how cost have grown relative to revenues after PPS. These rates show that cumulative cost increases have widely outstripped cumulative revenue increases from PPS-1 forward. This is why PPS margins have fallen so steadily over time.

Factors Underlying Hospital Cost Increases

A key question underlying the above statistics is "Why are hospital's costs increasing as they are?" Exhibit 10 contains a list of factors thought to influence hospital costs. This list of variables suggests that a very complicated set of phenomena impact upon hospital cost structures. I suspect that ProPAC, AHA and others will devote considerable effort in the future to determining the relative impact of these types of causal factors on hospital cost structures.

One thing I would like to point out after numerous discussions with hospital managers, is that once hospital managers adjust to PPS cost-cutting incentives, their ability to continue cost-cutting is diminished. There are only so many ways to cut computer budgets, adjust staff mixes, cut computer budgets and otherwise reduce unnecessary overhead. Once these steps are taken, continued cost reductions are more difficult to achieve. This is particularly true for those cost-cutting procedures that involve multi-year contracts.

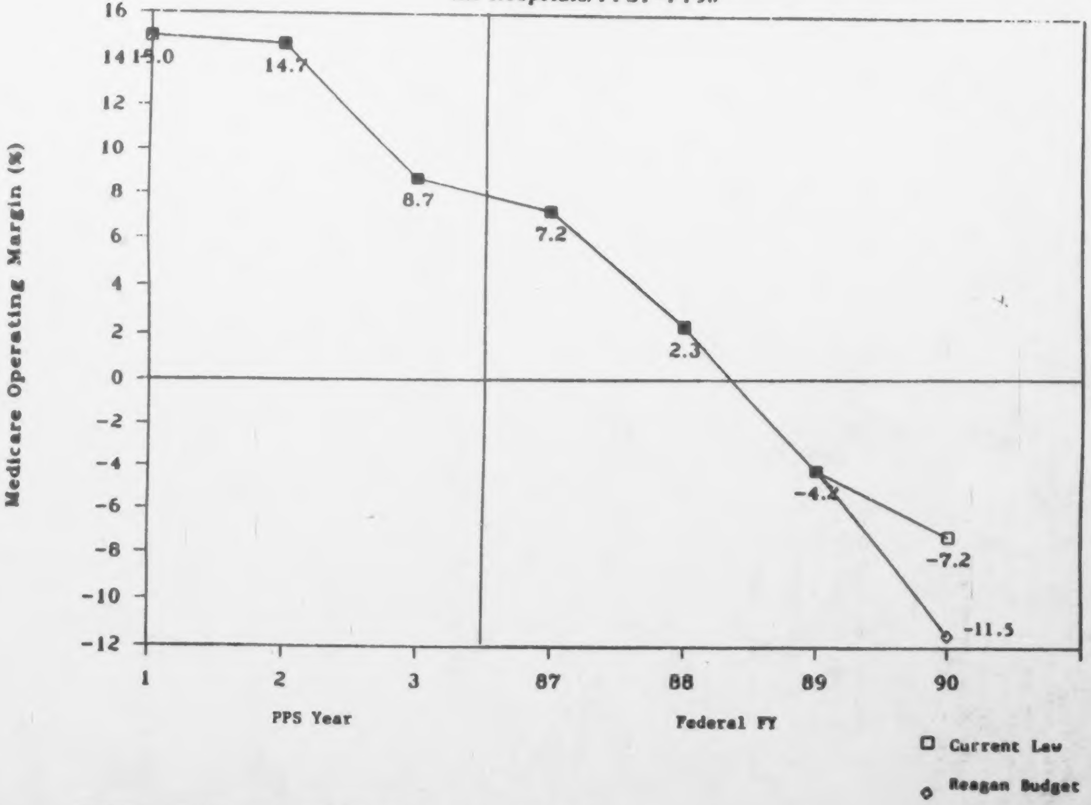
Conclusion

- Projections of Medicare Operating Margins depend upon a variety of assumptions and current projection models assume that hospitals will behave in the future as they have in the past. Cost are more difficult to project than revenues.
- Given four years of baseline cost data, it seems clear that as time passes, PPS is placing increasingly more financial pressure on hospitals. Hospital costs are currently rising faster than hospital revenues. If this imbalance is not eventually corrected, the financial solvency of many good institutions will be jeopardized.
- Hospital margin estimates vary widely across types of hospitals and geographic areas and for every given class of hospitals, there is wide variation of winners and losers around the class average. These differences are not necessarily related to efficiency.
- Hospitals with high initial costs apparently have not been able to protect themselves with effective cost-cutting strategies as PPS has been phased-in. This has resulted in very uneven hospital margins at the state level.
- There are numerous possible reasons why hospital costs are rising so rapidly, and careful study is required to pinpoint the exact causes in order that corrective action may be taken. It may be unrealistic to expect hospitals to continually decrease rates of cost increases after initial reductions have been achieved.

EXHIBIT 1

Case-Weighted Operating Margin

All Hospitals/PPS1-FY90



SOURCE: CONSOLIDATED CONSULTING GROUP (CCG/PSM)

EXHIBIT 2
MEDICARE CASE-WEIGHTED OPERATING MARGINS
ALL HOSPITALS BY HOSPITAL GROUP
PPS1-PPS7

Hospital Group	Actual Operating Margin[1]			Projected Operating Margin[2]			
	PPS1	PPS2	PPS3	PPS4	PPS5	PPS6	PPS7
All Hospitals	15.0	14.7	8.7	7.2	2.3	-4.2	-11.5
Urban							
Aggregate	16.3	15.9	9.4	8.2	2.8	-3.9	-11.5
Urban > 1 million	17.0	15.6	8.7	7.2	1.0	-5.8	-14.0
Other Urban	15.4	16.2	10.4	9.5	4.9	-1.6	-8.4
<100 Beds	14.5	12.8	7.6	5.4	2.1	-4.7	-10.6
100-404 Beds	15.1	14.5	8.4	5.8	0.2	-6.8	-13.3
405-684 Beds	16.6	17.5	10.6	10.2	4.4	-2.0	-10.7
685+ Beds	20.5	20.6	13.4	16.0	10.8	5.2	-4.9
Rural							
Aggregate	8.4	8.9	4.7	0.4	-1.1	-6.6	-12.2
<100 Beds	7.5	6.5	1.1	0.3	0.7	-3.7	-9.2
100-169 Beds	9.3	8.8	8.1	-1.0	-2.8	-8.7	-14.3
170+ Beds	8.8	11.7	6.0	1.1	-2.7	-9.2	-15.2
New England	12.0	13.3	8.5	3.4	-0.6	-7.2	-15.8
Mid-Atlantic	16.7	16.8	8.9	15.6	14.3	8.4	0.6
South Atlantic	13.2	14.0	6.6	2.5	-0.9	-8.3	-15.7
East North Central	15.4	14.5	10.4	12.0	-0.8	-7.6	-15.2
East South Central	10.7	13.0	5.7	3.2	3.1	-2.9	-8.7
West North Central	16.4	16.4	11.2	8.0	5.0	-0.8	-7.6
West South Central	16.9	14.2	8.6	2.8	-1.1	-7.5	-14.4
Mountain	14.8	18.1	12.6	8.2	5.6	0.1	-5.1
Pacific	15.9	14.4	7.4	2.1	-2.0	-9.0	-16.1
Teaching	17.7	18.1	11.0	11.4	5.7	-0.7	-10.1
Non-Teaching	12.8	12.0	6.8	3.2	-0.9	-7.4	-12.7
Church	15.0	15.4	9.6	8.6	2.1	-4.4	-11.1
Not-for-Profit	16.1	14.9	8.7	8.1	2.8	-3.6	-11.3
Proprietary	11.2	16.2	8.8	2.5	-0.3	-8.1	-13.8
Government	11.9	11.6	7.1	5.5	2.8	-2.8	-10.4
Disproportionate Share	16.4	16.4	9.8	11.3	7.4	0.9	-7.2
Non-Disproportionate Share	14.3	13.9	8.1	5.0	-0.4	-6.9	-13.7

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[1] Excludes Maryland, Massachusetts, New Jersey, New York and Puerto Rico.

[2] Excludes Maryland, New Jersey and Puerto Rico.

SOURCE: CONSOLIDATED CONSULTING GROUP, WASHINGTON, D.C.

EXHIBIT 3

COMPARISON OF OPERATING MARGINS/ALL HOSPITALS
HOSPITAL WEIGHTED MEAN AND PERCENTILES
BY YEAR

	PERCENTILES				
YEAR	10TH PERCENTILE	25TH PERCENTILE	MEDIAN	75TH PERCENTILE	90TH PERCENTILE
PPS1	-0.0747	0.0300	0.1130	0.1805	0.2424
PPS2	-0.1077	0.0198	0.1113	0.1876	0.2570
PPS3	-0.2037	-0.0478	0.0522	0.1343	0.2037
FFY87	-0.2489	-0.0930	0.0352	0.1471	0.2456
FFY88	-0.3209	-0.1393	0.0094	0.1395	0.2511
FFY89	-0.4198	-0.2134	-0.0492	0.0978	0.2221
FFY90	-0.5164	-0.2843	-0.1087	0.0496	0.1890

SOURCE: CONSOLIDATED CONSULTING GROUP PAYMENT SIMULATION MODEL (CCG/PSM)

Exhibit 4

COMPARISON OF MEDICARE OPERATING COSTS, REVENUES AND CASE-WEIGHTED MARGINS
TOTAL AND PER CASE BY HOSPITAL GROUP
MEDICARE HOSPITALS FY 1990

HOSPITAL GROUP	NUMBER OF HOSPITALS	% TOTAL DISCHARGES	OPERATING COST		REVENUES		OPERATING MARGIN
			PER CASE	TOTAL (IN THOUSANDS)	PER CASE	TOTAL (IN THOUSANDS)	
ALL HOSPITALS	5005	100.0	5,090	50,391,000	4,564	45,183,600	- 11.5%*
URBAN							
AGGREGATE	2582	76.3	5,624	42,476,032	5,042	38,080,397	- 11.5%
URBAN > 1 MILLION	1305	39.0	6,208	23,977,465	5,445	21,030,492	- 14.0%
OTHER URBAN	1277	37.3	5,013	18,499,413	4,621	17,052,820	- 8.4%
<100 BEDS	659	5.2	4,566	2,341,349	4,128	2,116,752	- 10.6%
100-404 BEDS	1513	44.1	5,400	23,549,849	4,765	20,780,561	- 13.3%
405-684 BEDS	329	20.1	6,060	12,059,647	5,473	10,891,493	- 10.7%
685+ BEDS	81	7.0	6,545	4,507,765	6,237	4,295,635	- 4.9%
RURAL							
AGGREGATE	2423	23.7	3,398	7,976,338	3,027	7,105,466	- 12.2%
<100 BEDS	1870	10.9	3,019	3,248,968	2,764	2,974,544	- 9.2%
100-169 BEDS	358	6.3	3,487	2,178,756	3,050	1,905,709	- 14.3%
170+ BEDS	195	6.5	3,966	2,563,488	3,441	2,224,146	- 15.2%
NEW ENGLAND	202	5.1	5,616	2,862,886	4,847	2,470,871	- 15.8%
MID-ATLANTIC	396	13.3	5,087	6,698,571	5,121	6,743,342	0.6%
SOUTH ATLANTIC	667	15.9	4,882	7,707,612	4,219	6,660,880	- 15.7%
EAST NORTH CENTRAL	803	19.0	5,274	9,916,701	4,577	8,606,132	- 15.2%
EAST SOUTH CENTRAL	447	8.9	3,912	3,449,544	3,599	3,173,545	- 8.7%
WEST NORTH CENTRAL	772	9.4	4,552	4,226,836	4,227	3,925,052	- 7.6%
WEST SOUTH CENTRAL	799	11.8	4,728	5,540,988	4,131	4,861,333	- 14.4%
MOUNTAIN	274	3.7	4,623	1,684,283	4,397	1,601,945	- 5.1%
PACIFIC	645	12.8	6,561	8,317,457	5,651	7,163,839	- 16.1%
TEACHING	856	38.1	6,102	23,010,252	5,538	20,883,444	- 10.1%
NON TEACHING	4149	61.9	4,472	27,409,173	3,965	24,301,738	- 12.7%
CHURCH	645	20.6	5,336	10,897,729	4,799	9,801,012	- 11.1%
NOT-FOR-PROFIT	2060	50.0	5,282	26,160,769	4,743	23,491,202	- 11.3%
PROPRIETARY	941	13.9	4,752	6,544,125	4,173	5,746,767	- 13.8%
GOVERNMENT	1359	15.4	4,446	6,792,380	4,024	6,147,669	- 10.4%
DISPRO. SHARE	1108	30.1	5,664	16,871,506	5,283	15,736,611	- 7.2%
NON-DISPRO. SHARE	3897	69.9	4,839	33,492,042	4,255	29,450,018	- 13.7%

* THE MEDICARE OPERATING MARGIN EXCLUDES HOSPITALS FROM MARYLAND, NEW JERSEY AND PUERTO RICO

SOURCE - CONSOLIDATED CONSULTING GROUP PAYMENT SIMULATION MODEL (CCG/PSM)

Exhibit 5

COMPARISON OF MEDICARE OPERATING COSTS, REVENUES AND CASE-WEIGHTED MARGINS
TOTAL AND PER CASE BY STATE
MEDICARE HOSPITALS FY 1990

HOSPITAL GROUP	NUMBER OF HOSPITALS	% TOTAL DISCHARGES	OPERATING COST		REVENUES		OPERATING MARGIN
			PER CASE	TOTAL (IN THOUSANDS)	PER CASE	TOTAL (IN THOUSANDS)	
ALL HOSPITALS	5005	100.0	5,090	50,391,000	4,564	45,183,600	- 11.5%*
ALABAMA	99	1.8	4,110	740,171	3,705	667,234	- 10.9%
ALASKA	16	0.0	7,336	32,153	5,714	25,044	- 28.3%
ARIZONA	38	1.0	4,954	506,973	4,569	467,574	- 8.4%
ARKANSAS	92	1.6	3,778	609,423	3,499	564,418	- 7.9%
CALIFORNIA	469	10.2	6,916	6,984,989	5,828	5,886,136	- 18.6%
COLORADO	46	0.6	5,009	297,497	4,958	294,468	- 1.0%
CONNECTICUT	32	1.1	6,665	752,695	5,379	607,464	- 23.9%
DELAWARE	7	0.3	5,042	145,460	4,285	123,621	- 17.6%
WASHINGTON, D. C.	10	0.4	7,580	289,813	6,067	231,965	- 24.9%
FLORIDA	204	6.4	5,238	3,340,169	4,457	2,842,140	- 17.5%
GEORGIA	136	2.3	4,184	932,138	3,796	845,696	- 10.2%
HAWAII	18	0.3	6,580	172,410	5,719	149,850	- 15.0%
IDAHO	22	0.3	4,034	110,952	3,723	102,379	- 8.3%
ILLINOIS	227	5.4	5,459	2,932,394	4,680	2,513,941	- 16.6%
INDIANA	115	2.7	4,855	1,309,058	4,245	1,144,583	- 14.3%
IOWA	120	1.3	3,729	463,523	3,671	456,314	- 1.5%
KANSAS	143	1.4	4,158	581,037	3,937	550,154	- 5.6%
KENTUCKY	97	2.2	3,821	844,988	3,677	813,143	- 3.9%
LOUISIANA	145	2.2	4,919	1,082,713	3,962	872,069	- 24.1%
MAINE	40	0.6	4,631	269,917	4,126	240,483	- 12.2%
(MARYLAND	51	1.9	5,095	952,453	4,675	873,938	- 8.9%)
MASSACHUSETTS	78	2.2	5,536	1,205,450	5,009	1,090,697	- 10.5%
MICHIGAN	153	3.2	5,905	1,894,490	4,911	1,575,587	- 20.2%
MINNESOTA	162	1.7	4,683	766,077	4,796	784,562	2.3%
MISSISSIPPI	108	1.7	3,099	515,860	3,071	511,199	- 0.9%
MISSOURI	145	3.2	5,132	1,617,440	4,433	1,397,137	- 15.7%
MONTANA	52	0.4	3,603	129,710	3,693	132,950	2.4%
NEBRASKA	96	0.8	4,403	360,927	4,107	336,663	- 7.2%
NEVADA	24	0.4	6,398	228,474	5,405	193,014	- 18.3%
NEW HAMPSHIRE	24	0.4	4,735	198,433	4,139	173,456	- 14.4%
(NEW JERSEY	89	3.4	5,139	1,731,494	4,825	1,625,697	- 6.5%)
NEW MEXICO	36	0.5	4,070	203,805	3,855	193,039	- 5.5%
NEW YORK	231	7.6	4,908	3,714,955	5,462	4,134,287	10.1%
NORTH CAROLINA	80	1.7	4,802	826,321	4,466	768,502	- 7.5%
NORTH DAKOTA	39	0.4	4,794	170,962	4,115	146,748	- 16.5%
OHIO	176	5.2	5,155	2,652,429	4,497	2,313,865	- 14.6%
OKLAHOMA	119	1.6	4,361	691,290	4,007	635,175	- 8.8%
OREGON	49	0.8	4,554	358,389	4,678	368,148	2.6%
PENNSYLVANIA	165	5.7	5,344	2,992,018	4,662	2,610,177	- 14.6%
(PUERTO RICO	42	0.6	2,152	135,951	1,804	113,966	- 19.2%)
RHODE ISLAND	14	0.6	5,697	315,533	4,795	265,575	- 18.8%
SOUTH CAROLINA	72	1.4	4,345	586,746	3,850	519,902	- 12.8%
SOUTH DAKOTA	56	0.5	3,448	159,099	3,446	159,007	0.0%
TENNESSEE	141	3.2	4,311	1,375,792	3,773	1,204,097	- 14.2%
TEXAS	444	6.4	5,001	3,172,774	4,384	2,781,331	- 14.0%
UTAH	35	0.4	4,144	159,810	4,337	167,253	4.4%
VERMONT	14	0.2	4,926	115,832	3,964	93,211	- 24.2%
VIRGINIA	100	2.6	4,698	1,199,919	4,020	1,026,751	- 16.8%
WASHINGTON	92	1.5	5,065	751,811	4,951	734,890	- 2.3%
WEST VIRGINIA	64	1.1	4,253	470,410	3,526	389,999	- 20.6%
WISCONSIN	138	2.3	4,709	1,086,714	4,470	1,031,559	- 5.3%
WYOMING	22	0.1	3,454	51,012	3,476	51,337	0.6%

* THE MEDICARE OPERATING MARGIN EXCLUDES HOSPITALS FROM MARYLAND, NEW JERSEY AND PUERTO RICO (CCG/PBM)

EXHIBIT 6
COMPARISON OF OPERATING MARGINS BY HOSPITAL GROUPS
HOSPITAL WEIGHTED MEAN AND PERCENTILES
PROJECTION FOR FY 1990 UNDER PROPOSED REAGAN BUDGET

	---------------------AVERAGE AND PERCENTILES--------------				
HOSPITAL GROUP	10TH PERCENTILE	25TH PERCENTILE	MEDIAN	75TH PERCENTILE	90TH PERCENTILE
ALL HOSPITALS	-0.5165	-0.2843	-0.1088	0.0496	0.1891
RURAL HOSPITALS	-0.5361	-0.2872	-0.0932	0.0746	0.2145
URBAN HOSPITALS	-0.5011	-0.2830	-0.1237	0.0313	0.1672
URBAN, BEDS<100	-0.6569	-0.3642	-0.0867	0.0990	0.2411
URBAN, BEDS 100-<405	-0.4792	-0.2811	-0.1340	0.0085	0.1334
URBAN, BEDS 405-<685	-0.3575	-0.2501	-0.1114	0.0166	0.1162
URBAN, BEDS>=685	-0.5516	-0.2196	-0.0776	0.1060	0.3300
RURAL, BEDS<100	-0.6033	-0.2864	-0.0719	0.1000	0.2473
RURAL, BEDS 100-<170	-0.4566	-0.2939	-0.1410	-0.0142	0.1077
RURAL, BEDS>=170	-0.4374	-0.2753	-0.1437	-0.0152	0.1055
NEW ENGLAND	-0.4934	-0.3212	-0.1438	-0.0103	0.0979
MID-ATLANTIC	-0.3747	-0.2168	-0.0328	0.1243	0.2845
SOUTH ATLANTIC	-0.4973	-0.3104	-0.1422	-0.0002	0.1458
EAST NORTH CENTRAL	-0.4677	-0.2831	-0.1533	-0.0095	0.0978
EAST SOUTH CENTRAL	-0.3778	-0.2010	-0.0578	0.1035	0.2313
WEST NORTH CENTRAL	-0.4451	-0.2420	-0.0406	0.1197	0.2487
WEST SOUTH CENTRAL	-0.7508	-0.4030	-0.1290	0.0380	0.1688
MOUNTAIN	-0.5490	-0.2633	-0.0544	0.1016	0.2899
PACIFIC	-0.5884	-0.3466	-0.1407	0.0221	0.1623
NON-TEACHING	-0.5299	-0.2888	-0.1030	0.0559	0.1967
TEACHING	-0.4580	-0.2723	-0.1306	0.0274	0.1646
CHURCH	-0.4135	-0.2554	-0.0984	0.0386	0.1721
NONPROFIT	-0.4464	-0.2631	-0.1074	0.0398	0.1778
PROPRIETARY	-0.6394	-0.3650	-0.1464	0.0315	0.1807
GOVERNMENT	-0.5918	-0.2990	-0.0861	0.0832	0.2260
NON-DISPROPORTIONATE	-0.5336	-0.3002	-0.1228	0.0392	0.1794
DISPROPORTIONATE SHARE	-0.4612	0.2418	-0.0649	0.0830	0.2145

SOURCE: CONSOLIDATED CONSULTING GROUP, WASHINGTON, D.C.

EXHIBIT 7
COMPARISON OF OPERATING MARGINS BY STATE
HOSPITAL WEIGHTED MEAN AND PERCENTILES
CCG-PSM FY 1990

HOSPITAL GROUP	10TH PERCENTILE	25TH PERCENTILE	MEDIAN	75TH PERCENTILE	90TH PERCENTILE
ALL HOSPITALS	-0.5165	-0.2843	-0.1088	0.0496	0.1891
ALABAMA	-0.4743	-0.2326	-0.1119	0.0146	0.1238
ALASKA	-2.0590	-0.6047	-0.2681	-0.1531	0.1779
ARIZONA	-0.5626	-0.3239	-0.1482	-0.0256	0.1260
ARKANSAS	-0.3782	-0.2336	-0.0615	0.0396	0.1325
CALIFORNIA	-0.6110	-0.3871	-0.1719	-0.0059	0.1296
COLORADO	-0.6078	-0.3555	-0.0929	0.0813	0.3088
CONNECTICUT	-0.6306	-0.4266	-0.2152	-0.1128	-0.0022
DELAWARE	-0.4155	-0.3062	-0.2741	-0.1285	0.2960
WASHINGTON, D.C.	-1.1088	-0.3975	-0.2917	-0.0776	0.1018
FLORIDA	-0.5380	-0.3771	-0.1873	-0.0420	0.0686
GEORGIA	-0.4404	-0.2021	-0.0343	0.1295	0.2575
HAWAII	-0.9647	-0.3776	-0.1196	0.0535	0.3562
IDAHO	-0.3939	-0.2516	-0.0011	0.3252	0.5104
ILLINOIS	-0.4895	-0.3080	-0.1686	-0.0454	0.0730
INDIANA	-0.4674	-0.2860	-0.1395	-0.0102	0.0923
IOWA	-0.3081	-0.1755	0.0136	0.1492	0.2641
KANSAS	-0.5199	-0.2668	-0.0924	0.0765	0.2025
KENTUCKY	-0.2412	-0.1352	0.0254	0.1361	0.3045
LOUISIANA	-0.8729	-0.4618	-0.1584	0.0114	0.1199
MAINE	-0.5209	-0.3355	-0.1309	0.0414	0.1670
MASSACHUSETTS	-0.4705	-0.2745	-0.1018	0.0204	0.1326
MICHIGAN	-0.7383	-0.4057	-0.2170	-0.0788	0.0596
MINNESOTA	-0.3462	-0.1222	0.0370	0.1733	0.2667
MISSISSIPPI	-0.3517	-0.1543	-0.0173	0.1345	0.2755
MISSOURI	-0.5168	-0.3528	-0.1972	-0.0276	0.0710
MONTANA	-0.2587	-0.0926	0.0382	0.1818	0.3626
NEBRASKA	-0.3516	-0.1659	0.0019	0.2014	0.3409
NEVADA	-0.7660	-0.4934	-0.2610	-0.1510	0.1871
NEW HAMPSHIRE	-0.3504	-0.2046	-0.0413	0.0443	0.1316
NEW MEXICO	-0.4953	-0.2159	0.0068	0.1211	0.2266
NEW YORK	-0.3028	-0.1479	0.0335	0.1917	0.3091
NORTH CAROLINA	-0.5467	-0.2508	-0.0958	0.0453	0.3249
NORTH DAKOTA	-0.4498	-0.2528	-0.0591	0.1212	0.2790
OHIO	-0.4316	-0.2613	-0.1632	-0.0380	0.0808
OKLAHOMA	-0.4227	-0.2154	-0.0364	0.1251	0.2476
OREGON	-0.4124	-0.1437	0.0177	0.2030	0.3856
PENNSYLVANIA	-0.4087	-0.2791	-0.1400	0.0225	0.1353
RODE ISLAND	-0.5300	-0.2775	-0.1530	-0.0839	0.1458
SOUTH CAROLINA	-0.4244	-0.2477	-0.1214	0.0252	0.1556
SOUTH DAKOTA	-0.4821	-0.2592	-0.0094	0.1695	0.3800
TENNESSEE	-0.4191	-0.2375	-0.1218	0.0421	0.2086
TEXAS	-0.8611	-0.4701	-0.1978	0.0007	0.1695
UTAH	-0.6102	-0.2728	-0.0368	0.0914	0.1722
VERMONT	-0.6115	-0.4430	-0.2645	-0.2170	-0.0111
VIRGINIA	-0.5059	-0.3420	-0.1671	-0.0676	0.0540
WASHINGTON	-0.5086	-0.2554	-0.1021	0.0592	0.2712
WEST VIRGINIA	-0.5244	-0.3905	-0.1707	-0.0221	0.1320
WISCONSIN	-0.2575	-0.1676	-0.0335	0.0798	0.1778
WYOMING	-2.2914	-0.2212	-0.0364	0.1378	0.2889
OTHER	-1.2671	-1.2671	-1.2671	-1.2671	-1.2671

SOURCE: CONSOLIDATED CONSULTING GROUP, WASHINGTON, D.C.

Exhibit 8

13:52 WEDNESDAY, FEBRUARY 22, 198

ANALYSIS OF PPS VARIABLES BY STATE

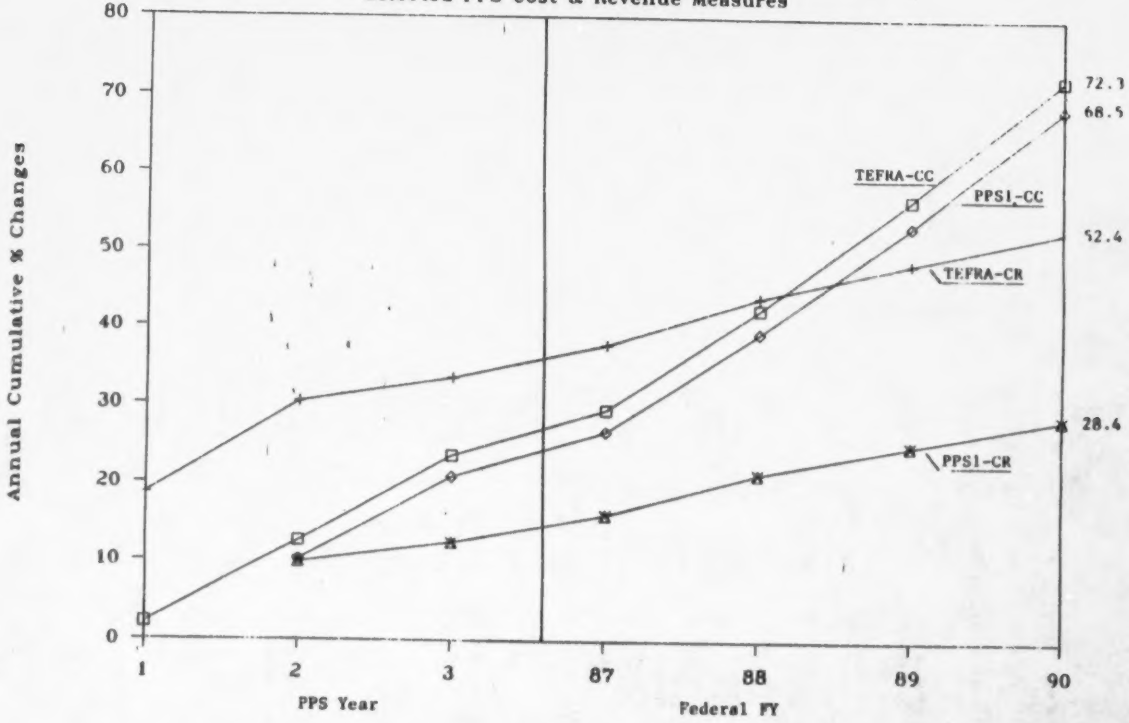
STATE CODE	STATE NAME	HS AMT PER CASE	RANK HS	PPS1-PPS3 ANNUAL INCREASE	RANK PPS1-PPS3	PPS3 OPERATING MARGIN	RANK PPS3 OM	PPS7 REAGAN BUDGET OP. MG.	RANK PPS7 OM
1	ALABAMA	2443.18	14	0.089811	22	7.9	21	-10.9	26
2	ALASKA	3734.17	46	0.084843	18	-4.0	1	-28.4	1
3	ARIZONA	2854.37	32	0.058119	5	10.2	32	-8.4	30
4	ARKANSAS	1952.86	1	0.127240	47	7.9	20	-8.0	31
5	CALIFORNIA	3697.74	45	0.100505	33	6.7	15	-18.7	9
6	COLORADO	2900.81	35	0.090302	23	18.3	45	-1.0	40
7	CONNECTICUT	3037.44	36	0.126012	46	9.4	27	-23.9	5
8	DELAWARE	2885.43	34	0.081779	16	1.4	3	-17.7	11
9	WASHINGTON D.C.	4883.93	47	0.042385	2	8.9	26	-24.9	2
10	FLORIDA	2758.62	30	0.096292	32	7.7	19	-17.5	12
11	GEORGIA	2124.31	4	0.103489	35	3.0	7	-10.2	27
12	HAWAII	3123.93	40	0.107012	40	2.6	6	-15.1	17
13	IDAHO	2545.27	21	0.104760	37	3.2	9	-8.4	29
14	ILLINOIS	3294.66	43	0.079871	15	8.3	24	-16.6	14
15	INDIANA	2822.69	31	0.093071	28	8.1	22	-14.4	21
16	IOWA	2220.11	6	0.075991	11	24.2	47	-1.6	39
17	KANSAS	2618.92	26	0.062938	6	11.0	38	-5.6	35
18	KENTUCKY	2175.30	5	0.074682	10	6.9	16	-3.9	37
19	LOUISIANA	2609.70	25	0.095313	30	2.6	5	-24.2	4
20	MAINE	2525.25	18	0.073822	9	5.4	11	-12.2	25
23	MICHIGAN	3289.49	42	0.091793	26	10.0	30	-20.2	7
24	MINNESOTA	2528.61	19	0.091011	24	9.7	28	2.4	44
25	MISSISSIPPI	1972.14	2	0.066540	7	7.2	17	-0.9	41
26	MISSOURI	3071.04	38	0.096005	31	10.3	34	-15.8	16
27	MONTANA	2277.75	7	0.043199	3	12.9	41	2.4	45
28	NEBRASKA	2397.96	11	0.102140	34	4.7	10	-7.2	33
29	NEVADA	3452.30	44	0.105721	38	8.1	23	-18.4	10
30	NEW HAMPSHIRE	2576.54	23	0.078717	14	6.5	14	-14.4	20
32	NEW MEXICO	2583.48	24	0.051198	4	10.8	35	-5.6	34
34	NORTH CAROLINA	2373.05	10	0.121331	44	10.2	31	-7.5	32
35	NORTH DAKOTA	2461.77	16	0.093452	29	1.2	2	-16.5	15
36	OHIO	3050.64	37	0.076386	13	11.6	39	-14.6	19
37	OKLAHOMA	2466.20	17	0.087248	21	9.9	29	-8.8	28
38	OREGON	2870.62	33	0.104586	36	12.9	42	2.7	46
39	PENNSYLVANIA	3249.67	41	0.092933	27	8.9	25	-14.6	18
41	RHODE ISLAND	3114.55	39	0.085076	19	10.9	37	-18.8	8
42	SOUTH CAROLINA	2371.97	9	0.107434	41	6.4	13	-12.9	24
43	SOUTH DAKOTA	2082.18	3	0.071049	8	10.9	36	-0.1	42
44	TENNESSEE	2404.88	12	0.086268	20	3.0	8	-14.3	22
45	TEXAS	2724.91	29	0.120108	43	10.3	33	-14.1	23
46	UTAH	2354.79	8	0.082778	17	20.0	46	4.5	47
47	VERMONT	2433.91	13	0.106600	39	7.5	18	-24.3	3
49	VIRGINIA	2548.66	22	0.091237	25	5.9	12	-16.9	13
50	WASHINGTON	2448.37	15	0.107793	42	12.3	40	-2.3	38
51	WEST VIRGINIA	2691.29	27	0.125914	45	2.0	4	-20.6	6
52	WISCONSIN	2708.79	28	0.076033	12	15.5	43	-5.3	36
53	WYOMING	2529.65	20	0.039501	1	16.4	44	0.6	43

ALL VARIABLES ARE CASE WEIGHTED
MD., MASS., N.J., N.Y., AND PUERTO RICO ARE EXCLUDED
CONSOLIDATED CONSULTING GROUP, WASHINGTON, D.C.

EXHIBIT 9

Cumulative Percentage Changes

Selected PPS Cost & Revenue Measures



SOURCE: CONSOLIDATED CONSULTING GROUP (CCG/PSM)

EXHIBIT 10

FACTORS THOUGHT TO INFLUENCE HOSPITAL COSTS

Pressure for Lower Costs

- PPS Payment Incentives
- Hospital Productivity and Efficiency
- Cost-Reducing Technologies

Pressure for Higher Costs

- Hospital Market Basket Cost Increases
- Cost-Enhancing Technologies
- Lower case loads associated with declining admissions (Economics of Scale) and resultant excess capacity
- Labor Shortages (especially nurses)
- Increased hospital inpatient severity not paid for by PPS (within DRG CMI increases) requiring more units of service -- intensity -- per case.
- Movement of more care to outpatient settings resulting in excess capacity and higher patient severity.
- Cost of routine supplies, AIDS prevention and liability insurance
- Mixed Incentives from PPS: Early revenues were relatively high and lead to a false sense of security.
- Rigidity of multi-year contracting process.
- Poor management

SOURCE: CONSOLIDATED CONSULTING GROUP, WASHINGTON, D.C.

Chairman Stark. Thank you, Doctor. One of the things that I often look at, and because we have Mr. Berman here I want to just follow up on this.

I go back to your exhibit 5, and find that the two largest States, both of which have rural and urban situations, and both of which have distinguished teaching hospitals, and both of which have high disproportionate share and impacted inner city neighborhoods, are so wildly different.

You show that the operating cost per case in California is down near $7,000—$6,916—and New York almost $5,000—$4,900, whereas the revenues are far more in line. They are $5,400 in New York and $5,800 in California, so California is losing 18 percent, and New York is making 10 percent.

And I suspect that another figure is that New York as a State is operating somewhere in the 90's in occupancy, and that California as a State, on average, is operating in the high 50's on occupancy.

Can you draw a conclusion from those numbers?

Mr. Berman. Well, the conclusion I would draw is that, if you had a system, and without picking the two States, where you have excess capacity at 40 percent, or half the capacity as excess, you would not expect all the providers to be making money.

In a State or in a situation where the supply and demand are a lot closer, and where that price has, in fact, been stabilized, you would be more concerned if there were that many losing.

So I think it is directly related to supply, and to capacity, and I think when you do the other numbers, and when you punch out the occupancy numbers, you will see—I mean, we would expect that any pricing system, whether it be marketplace, regulatory or whatever—would, in fact, discourage or stop the production of excess supply.

And therefore, to do it, it has to have negative numbers. If it keeps everybody in business it is not going to be very good.

So I think your question about plugging out the numbers should be directly related to that.

Mr. Dobson. If I could make a comment on those two numbers.

Chairman Stark. Please.

Mr. Dobson. One thing that I discovered when I looked at New York, I believe Massachusetts, and other regulated States, is that generally speaking they had by PPS-3, I believe it was, case per costs of in the $4,600 to $4,900 per case.

I think Mr. Berman is being a bit too modest. When New York put the regulatory apparatus in place, I calculate that the rate of increase of costs in New York from PPS-1 to PPS-3 were very, very low, if the national average was, say, 9 to 10 percent, and New York was maybe 3 to 4 percent.

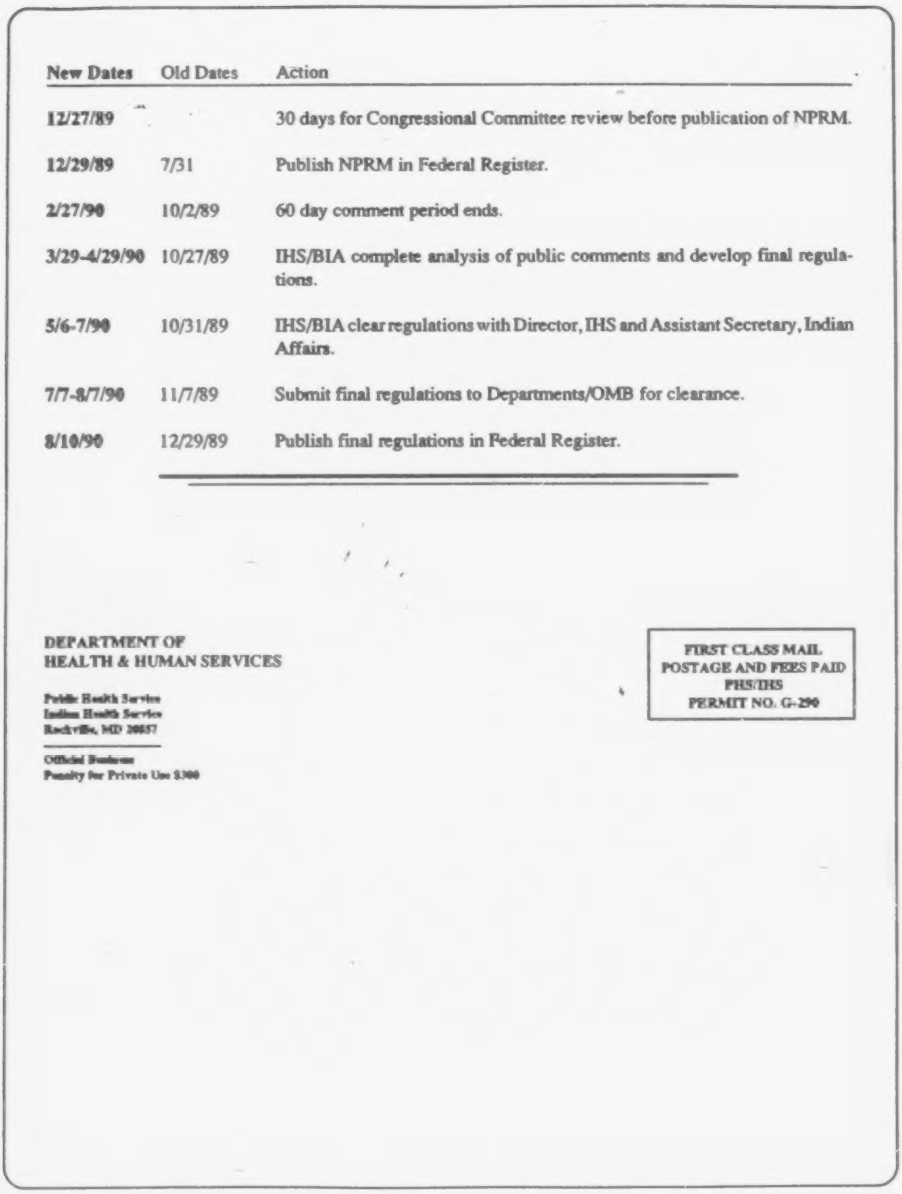
Well, by the time you get to the PPS-3 base, that really cumulates, and the costs were just very low. In part, perhaps, because of occupancy, but in part because of some very forceful action taken on the part of the State.

Chairman Stark. For the DRG system to work, the DRG's have to take their toll. And ~~then if~~ we keep rescuing those who should fail, which is the result that was intended, I believe, in the DRG system, we are indeed subverting the system.

The newly revised schedule now in effect is:

NOTE: The following target dates are estimates based on the minimum time required by the various steps. They are presented in order to outline the process. Any slippage at any stage will delay the publication date of the Final regulations an equivilent period of time.

New Dates	Old Dates	Action
4/4-12		Copy and mail RDW II Working Documents to RDW I and RDW II participants and persons on mailing list.
4/3-5/12	3/27-4/14	IHS and BIA prepare Notice of Proposed Rulemaking (NPRM) using RDW II Working Document as basis.
5/15-19		Mail draft IHS NPRM to Steering Committee for study.
5/23-24		Steering Committee meeting to review draft IHS NPRM.
5/30-6/2		IHS/BIA refine draft joint NPRM.
6/5-9		IHS/BIA clear draft joint NPRM with Director, IHS and Assistant Secretary, Indian Affairs. (Hearafter, all references to draft NPRM mean draft joint NPRM.)
6/12-16	4/17-21	Copy draft NPRM and mail to persons on mailing list.
6/19-7/7	4/24-5/5	3 weeks to study draft NPRM before joint IHS/BIA/Tribal meetings in Areas.
7/10-14	5/8-12	Joint IHS/BIA/Tribal meetings in Areas to review draft NPRM.
7/17-28	5/15-19	Receive, copy and mail results of joint IHS/BIA/Tribal meetings to Steering Committee members.
8/1-2 (?)		Steering Committee meeting to review results of joint meetings.
8/7-25	5/22-26	Revise draft NPRM based on results of joint IHS/BIA/Tribal meetings and Steering Committee meeting.
8/23-25 (?)		Steering Committee meeting to review revised NPRM before clearance.
8/28	5/29	IHS/BIA submit NPRM for clearance by Departments (DHHS and DOI), OMB, and Congressional Committees.
10/27/89		60 days (minimum) required by DHHS to review, clear NPRM.
11/27/89		30 days (minimum) required by OMB to review, clear NPRM.



New Dates	Old Dates	Action
12/27/89		30 days for Congressional Committee review before publication of NPRM.
12/29/89	7/31	Publish NPRM in Federal Register.
2/27/90	10/2/89	60 day comment period ends.
3/29-4/29/90	10/27/89	IHS/BIA complete analysis of public comments and develop final regulations.
5/6-7/90	10/31/89	IHS/BIA clear regulations with Director, IHS and Assistant Secretary, Indian Affairs.
7/7-8/7/90	11/7/89	Submit final regulations to Departments/OMB for clearance.
8/10/90	12/29/89	Publish final regulations in Federal Register.

DEPARTMENT OF
HEALTH & HUMAN SERVICES

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Pala Band Of
Mission Indians

P.O. Box 43
Pala, California 92059-0043
(619) 742-3784

To : **Senator Daniel K. Inouye**
Honorable Members of the Senate Select Committee
on Indian Affairs

From : **Patricia R. Nelson,** *Chairwoman*
Pala Band of Mission Indians

On behalf of the Pala Band of Mission Indians, and the 646 Band members we represent, we wish to express our appreciation for the opportunity to speak before this body today. The Pala Band commends you Senator Inouye for your interest in our people and we offer this testimony with the intention of providing an accurate and concise picture of our problems, our fears and our desires.

The Pala reservation is situated in the most affluent and prosperous section of north San Diego County. The land adjacent to ours is nurtured, cultivated, and blanketed by citrus, avocados, golf courses, and million dollar homes while our 11,000 acres sits barren, riddled with abandoned vehicles, dirt roads and littered with bags and barrels of trash and chemicals dumped by evasive non-Indians.

The Pala reservation is not now how we'd like it to be - the membership of the Band is frightened by the many non-Indians who have made our home a dumping ground for their illegal chemicals; a point of sell for illicit drugs and weapons; a night time playground for those of us who have succumbed to the hook of drugs and alcohol.

We want very much to take charge - to restrict, expel, and confine those that break your laws and ours. Yet, we are made powerless by the nebulous language of Public Law 280, and impotent by the lack of funds or support from either the State of California or the Bureau of Indian Affairs. Instead, we tread lightly, and beseech all Gods to watch over our children, our seniors, and the innocent whose very lives are now in danger.

We want very much to take responsibility for those who have become anesthetized to the pain of poverty and unemployment by drugs and alcohol. We want to take them and lead them to recovery - yet, we are made helpless by the absence of funds with which to do so. As Tribal leaders we are left feeling unbefitting of our positions as we search, in vain, for beds in half-way houses, or rehabilitation centers - beds that simply are not, and never will be there - beds that only money can buy.

We want to take our land and use it, just as our non-Indian neighbors do now, to become self-sufficient, strong, and capable. And yet, we find that the costs associated with developing a viable business plan are considerable and the processes involved mystifying to most tribal decision-makers, the people. When the membership was once asked to spend $30,000. on a feasibility study and market analysis, one Band member asked, "What if it shows the idea won't work?" "We'd just lose the money and get nothing in return. . .". The idea of being "careless" with what little money the Band now has is abhorrent - the Pala Band, like most, has gone through decades of "study" - always by someone else, seldom, if ever with any result.

The economic development process is the most critical issue facing the Pala Band. The need to start some type of income generating activity is an immediate, and urgent, need. The Band is anxious to explore the economic development arena, as documented by a recent survey which revealed that 69% of the Pala people supported the initiation of some type of economic enterprise.

The interests of the people is what the Tribal Government is obligated to act on; and yet, we have no support, no money, no agency, no advisor who can facilitate the process. We must find a means of enabling the Pala Band through education of the membership, study, and economic analysis, without high risk, great expense, and much sacrifice by the people.

The Pala Band now contributes almost $ 100,000. of our own money to our Boys Club, our Cultural Center, our Education Center, and our Fire Department - these are the only avenues open to us - the only shoreline in our ongoing struggle to protect our land, promote our children, and honor our ancestors. The Pala people cannot and should not be asked to forgo support for these causes today, so that a means can be found for an economically stable tomorrow.

We look to you Senator Inouye, the respected members of this Committee, and the Congress of the United States, to assist us in gaining the technical expertise and financial support required to stabilize our economy, be it through seed-money, grants, or loans. We look to you Senator Inouye and the Congress of the United States to assist us in finding a means to implement our programs, and in doing so ameliorate our problems, without taxing our limited financial resources, without hurting those most in need - the Indian people of the Pala Reservation.

Our thanks for this chance to speak with you today - with candor, and sincerity.

Pala Band Of
Mission Indians
P.O. Box 43
Pala, California 92059-0043
(619) 742-3784

1989 Census Report

POPULATION	Total	%
Male	374	51 %
Female	400	49
Native American	445	58 %
White	47	12
Black	1	.002
Hispanic	97	27
Asian	0	.005
Other	32	.026

EMPLOYMENT - # Working		
None	67	33 %
One	86	45
Two	33	18
Three or More	15	4
TOTAL	98	100 %

DESIRED ECONOMIC BASE ACTIVITY		
Yes	137	69.4 %
No	43	30.6

TYPE ECONOMIC ACTIVITY MOST DESIRED	
Amusement Park	18.9 %
Indian Museum	14.9
Light Industry	12.3
Resort	11.0
Heavy Industry	9.8
Crafts	8.7
Water Resource Marketing	8.1
Agriculture	6.3
Restaurant	4.6
Other	3.4
Animal Husbandry	1.2
None	0.8
TOTAL	100.0 %

AGE HEAD OF HOUSEHOLD		
18 - 24	4	3 %
25 - 34	49	25
35 - 44	49	25
45 - 54	36	18
55 - 64	24	12
65 - 74	25	12
75 & Over	11	5
TOTAL	198	100.0 %

LENGTH OF TIME RESPONDENT		
Less than 1 year	10	5 %
1 - 5 years	21	10
5 - 10 years	20	10
10 - 20 years	36	17
20 - 30 years	32	15.
More than 30 years	89	43
TOTAL	208	100 %

LEVEL OF EDUCATION		
Some Grade School	12	6 %
Grade School	5	3
Some High School	58	29
High School Graduate	47	24
Some College	57	28
College Graduate	3	2
Some Graduate School	5	3
Graduate Degree	10	5
TOTAL	197	100 %

INCOME LEVEL		
$ 5,000. & below	39	26 %
5,001 - 10,000	35	23
10,001 - 15,000	25	16
15,001 - 20,000	15	10
20,001 - 25,000	12	8
25,001 - 30,000	10	6
30,001 - 40,000	11	7
40,001 - 50,000	3	2
over 50,000	3	2

EMPLOYMENT CATEGORIES		
Professional/Tech	37	28 %
Admin/Managers	18	13
Sales	8	6
Craftsmen	0	0
Clerical	14	11
Construction/Labor	23	17
Farm Labor	9	7
Personal Household	6	5
Other Labor or Service	17	13
TOTAL	132	100 %

CONDITIONS ON RESERVATION		
Improved	81	39 %
Remained the Same	69	33
Worsened	57	27
TOTAL	207	100 %

SAN LUIS REY INDIAN WATER AUTHORITY

SAN LUIS REY INDIAN WATER AUTHORITY

1989 Census Report - Pala, Pauma, Rincon, La Jolla & San Pasqual

Demographic Information

POPULATION	Total	%
Male	1436	51 %
Female	1387	49
Native American	1431	58 %
White	292	12
Black	5	.004
Hispanic	659	26
Asian	15	.006
Other	64	3

AGE HEAD OF HOUSEHOLD		
18 - 24	50	7 %
25 - 34	208	27
35 - 44	221	29
45 - 54	116	15
55 - 64	81	11
65 - 74	54	7
75 & Over	27	4
TOTAL	757	100 %

INCOME LEVEL		
$ 5,000. & below	197	29 %
5,001 - 10,000	170	25
10,001 - 15,000	111	16
15,001 - 20,000	73	11
20,001 - 25,000	49	7
25,001 - 30,000	40	6
30,001 - 40,000	29	4
40,001 - 50,000	17	2
over 50,000	4	.005

EMPLOYMENT - # Working		
None	245	33 %
One	339	45
Two	138	18
Three or More	30	4
TOTAL	752	100 %

DESIRED ECONOMIC BASE ACTIVITY		
Yes	344	77 %
No	105	23

TYPE ECONOMIC ACTIVITY MOST DESIRED	
Water Resource Marketing	18 %
Indian Museum	14
Amusement Park	13
Resort	12
Light Industry	11
Heavy Industry	9
Crafts	7
Other	5
Agriculture	5
Restaurant	4
Animal Husbandry	1
None	1
TOTAL	100

LENGTH OF TIME RESPONDENT		
Less than 1 year	145	19 %
1 - 5 years	149	19
5 - 10 years	101	13
10 - 20 years	135	17
20 - 30 years	67	9
More than 30 years	177	23
TOTAL	774	100 %

LEVEL OF EDUCATION		
Some Grade School	47	7 %
Grade School	33	5
Some High School	209	31
High School Graduate	168	24
Some College	184	27
College Graduate	11	2
Some Graduate School	12	2
Graduate Degree	19	2
TOTAL	683	100 %

EMPLOYMENT CATEGORIES		
Professional/Tech	130	22 %
Admin/Managers	43	7
Sales	26	4
Craftsmen	22	4
Clerical	41	7
Construction/Labor	113	19
Farm Labor	92	16
Personal Household	32	6
Other Labor or Service	88	15
TOTAL	587	100 %

CONDITIONS ON RESERVATION		
Improved	269	36 %
Remained the Same	325	44
Worsened	151	20
TOTAL	745	100 %

Pala Band Of
Mission Indians
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THE PALA BAND

General Information

The Pala Band of Mission Indians is comprised of 646 enrolled members of Cupeno or Luiseno descent. The reservation was purchased with the intent of providing a home to a small Band of "Cupeno" who were then living at Warners Hot Springs. The historical homesite, Warner Hot Springs, was given away via a Mexican Land Grant. The United States Government supported this action and used federal troops to relocate the Cupeno to Pala in 1903. Cupeno is Spanish and means the people who live by the warm waters. When the Cupeno arrived at Pala, there was also a small Band of Luiseno, originally affiliated with either the Rincon or Pechanga Bands, living there; thus the placement of two different Tribes on one reservation - not common in Southern California.

The federal government provided prefab homes, shipped in from New York, in replacement for the adobe dwellings the people had constructed at Warners. These one room units offended the people since they were inferior in both size and quality to what they left behind. These prefab units were placed in one central area, called the village. One still stands. The reservation is 11,000 acres, the majority of which is in the mountains behind the village. Pala means water in our language.

The Pala Executive Committee is elected by the General Membership to conduct the business of the Band. They are:

Patricia R. Nelson, Chairwoman
Robert Smith, Vice-Chairman
Debora Smith, Secretary
Loretta Linton, Treasurer
Henry Smith, Committee Member
Jane Blackmon, Committee Member

The Band maintains a tribal office which employs a team of tribal members to provide the membership with services in the area of water, sewer, cable, road maintenance, enrollment & membership records, land records. They are: **Debbie Smith, Nikki Freeman, Carmelita Ryan, Teresa Skaggs, Neomi Boles, Walter Smith, Doug Freeman, Leatha Diaz, Mike Guachino.**

PALA SECURITY DEPARTMENT - In 1977 the Pala Band obtained an employment position through the Comprehensive Employment and Training Act to hire a Security man. This individual, **Henry Smith,** is responsible for patrolling the reservation and coordinating our law and order needs with the local sheriffs department. In 1979 when CETA funds became unavailable the Band allocated the money to continue the position. The increase in resident population prompted the Band to add another security position, filled by tribal member **Leroy Miranda** in 1988. The Band contributes $30,000. for this service.

PALA FIRE DEPARTMENT - Located in the heart of the village, the Pala Fire Department started in 1980 with $ 27,000. in fire protection funds available from the Bureau of Indian Affairs. The 1990 allocation will be $13,000. In 1988 the Band contributed $60,000. for the construction of permanent facilities. A Captain and two firefighters, with the cooperation and support of a team of fourteen (14) community volunteers, man the station 24 hours per day. The Band contributes $58,000. to augment BIA funds.

The Captain of the Department is **ROBERT SMITH.** Firefighters are **Juan Luna** and **Kyle Perez.** Secretary for the department is **Marisa Ravago.** Volunteers are:

Anthony Ravago, Sr.
Leroy Hutton
Jaime Luna
Henry Smith
Tony Suarez
Mario Moro
David Garcia
Shelia Smith
Chuck Gabbard
Roy Nieto
Carol Coultress, Jr.

All of the above are Firefighters and 6 are certified as Emergency Medical Technicians (EMTs). They are all tribal community residents. The Volunteers have meetings once a month at which they plan their training, education, and work schedules. They also hold various types of fund-raisers throughout the year, such as food sales, raffles, and dances to contribute to the support of the Station. Last year this group raised $3,000.

PALA AVOCADO PROJECT - At 55 acres the Band has one of the largest avocado groves in the valley. The project began in 1979 with funds received from the Department of Housing and Urban Development, CETA (private sector initiative), and the Economic Development Administration. The Band invests approximately $50,000 per year for maintenance, management and repairs. The project returned $105,000. in 1988. The goal is to expand the grove to 250 acres, as per the wishes of the Membership. The Grove is maintained by a management contract with **Jim Devers** who is employs tribal member **Charles Lawton** as his assistance.

CULTURAL CENTER - This combination cultural center, museum, and craft classroom, was built entirely with donations from Pala and neighboring communities. It was constructed in memory of the move from our original homesite, Warners Hot Springs, to Pala in 1903. The Band contributes $15,000. annually to defray operating and instruction costs. The Director of the Center and Chairman of the Board is **CLIFFORD "Tanty" DIAZ**, an enrolled Pala Band member. His salary, as well as the cost of craft supplies and equipment, is paid through a grant received from the California Community Arts Foundation. The Center holds beading, pottery, and other "Indian" craft classes for community residents on a regular basis. The Cupa Cultural Center holds a yearly festival in honor of the move the first part of May each year. This is their major fund-raising event. All other community non-profit organizations have booths to raise funds for their individual interests/projects at this event as well.

Tribal Members of the community who sit on the Cultural Center Board of Directors are:

Helen Crane, Vice-Chairwoman **Carmelita Ryan, Secretary**
Margaret Hilton, Treasurer **Jane Blackmon, Member**
Patricia Agneta, Member **Carol Hutton, Member**
Secretary for the Cultural Center is **Lela Gabbard**.

PALA BOYS & GIRLS CLUB - The Band paid for the construction of this facility from tribal funds in 1980. Community volunteers donated labor, materials, and time to complete the project. It now receives $20,000 from the United Way, via the Fallbrook Boys & Girls Club, and $20,000. from the Band. It is the only official branch of a Boys & Girls Club on an Indian reservation. The club services the 500 (+) children of the reservation. It is directed by **DAVID GARCIA**, an enrolled member of the Rincon Band.

Lee Ann Hayes **Angelo Lavato** **Eugene Magee**
Mario Moro **Jane Blackmon**

PALA MISSION & SCHOOL - The Mission San Antonio de Pala was built as a substation to the Mission San Luis Rey in Oceanside in 1814. The Mission will be celebrating its 175th Birthday next week with a special mass said by the Bishop. The interior of the church is quite beautiful and is the only part of the California Mission system that still ". . serves the Indians." It was built with Indian labor.

SAN LUIS REY
INDIAN
WATER AUTHORITY

A Tribal Corporation Serving
the La Jolla, Rincon, Pala,
San Pasqual and Pauma Bands
of Mission Indians

Executive Board

Henry N. Rodriguez
President, La Jolla

Edward T. Arviso
Vice-President, Rincon

Patricia R. Nelson
Treasurer, Pala

James Quisquis
Secretary, San Pasqual

Leland A. Majel
Committee Member, Pauma

Directors

Robert Lofton
La Jolla

Douglas Calac
Rincon

Stan McGarr
Pala

Paul Contreras
San Pasqual

Benjamin Magante
Pauma

SENATOR INOUYE and Members of the Committee:

My name is Henry Rodriguez. I am an enrolled member of the La Jolla Band of Mission Indians.

I'd like to thank you for the opportunity to speak before this body today and do so in my capacity as President of the San Luis Rey Indian Water Authority.

The San Luis Rey Indian Water Authority is a tribally chartered organization created to represent the interests of the **Pala, Pauma, Rincon, La Jolla** and **San Pasqual Bands** in litigation over the rights to the San Luis Rey River.

The dispute, which involved the diversion of the water of the San Luis Rey River into the cities of Escondido and Vista, was resolved by the 100th Session of Congress with their passage of S. 795, the "San Luis Rey Indian Water Rights Settlement Act". The passage of this Act represents the first opportunity in over 100 years for the Bands to take full responsibility for the future. It concludes 20 years of deprivation and signals the start of a new era whereby the 5 Bands may build new life on the reservations, renew lost hopes and promote self-sufficiency through the creation of economic opportunities.

Briefly, the legislation authorizes an allocation to the Bands of 16,000 acre feet of water and a $ 30 million dollar economic development trust fund. The water will be available to support the domestic, irrigation, and industrial needs of the Bands while the trust fund may be leveraged to address capital requirements of desired enterprises.

While a conclusion to our dispute with the cities of Escondido and Vista represents a giant step towards self-sufficiency, it cannot be considered a panacea to all of the Bands problems. The Authority has been given very clear and direct guidlines, by the Congress, to utilize all resources generated through, and by, a settlement to suppport the economic growth and development of our reservations. The Authority cannot be expected to either supplant Bureau of Indian Affairs, Public Indian Health, or other agency services or monetarily support the operations of programs to accomodate specific social, cultural, or health needs.

The fears of the community have been fueled of late by a series of crimes on all of the reservations served by the Authority. Murders, drug arrests, drive-by shootings, child abuse, and other types of violations common to economically depressed communities, are now regular occurances on our

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reservations. Solutions must be found for these and other problems which negatively impact the health, safety and well-being of our tribal communities. Solutions, however, cost money - money that that Bands simply do not have.

Environmental problems, which will be addressed in more detail by the Rincon Band, are other areas of major concern. The County of San Diego is looking for a site for the placement of a municipal land fill and is considering two areas both of which are adjacent to the Pala reservation.

One of the proposed dump site abutts a large rocky mountain, called Indian rock, which was historically used by the Luiseno for religious purposes. This mountain is believed to be the home of a mystical religious figure central to their religion and culture. Yet, this value is readily discounted by County officials whose concerns are for the "...500,000 people. . . " for whom a dump must be found.

The Bands are also concerned about the potential of both dump sites to contaminate the ground water and while the Pala Band, and their tribal neighbors, have gone on record in opposition to the two sites under consideration, the Band has neither the financial resources, nor the technical support from the Bureau of Indian Affairs, or any other agency, to provide the hydrological studies needed to document the potential of contamination.

The Southern California Bands are more often than not helpless and unable to take full responsibility for ourselves, our people, and our resources. We have neither the money, nor the expertise, to intitate the types of drug and alcohol recovery or counseling programs we need and desire. Thre is no agency, no vehicle, no funding allocation that we can look to for assistance with the types of educational, cultural, or training programs we need and desire.

And so Senator Inouye, and honorable members of the Committee, please be aware that in Southern California there exists a very real, and ever present, need to provide the Bands with some type assistance, be it financial or technical. We must become more enabled; we must have available the resources with which to protect the Bands from situations which might be harmful to the health, safety and well being of the memberships.

We honestly believe that the Bureau of Indian Affairs, as part of their trust responsibility, must be more instrumental in providing us with the means to challenge the plans of developers and others whose sole objective is to make a profit at the expense of the people who live on the reservations.

We honestly believe that the problems of our 5 reservations will continue to increase, just as they have over the last 20 years, until such time as the Congress of the United States corrects the inequity in funding to California Indians by the Bureau of Indian Affairs. Until such time, the Southern California Indians will continue to fend for themselves, continue to attempt our own corrections, insufficent though they might be, all at tremendous cost to the livelihood, the environment, and the spirit of our people. We need your help, Senator Inouye, and the help of the Congress of the United States, to provide us with the type of technical and financial infusion that will bring our tribal communities back to life.

Thank you.

A:\HENRY

SAN LUIS REY INDIAN WATER AUTHORITY

SAN LUIS REY
INDIAN
WATER AUTHORITY

1989 Census Report - Pala, Pauma, Rincon, La Jolla & San Pasqual

Demographic Information

POPULATION	Total	%
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White	292	12
Black	5	.004
Hispanic	659	26
Asian	15	.006
Other	64	3

EMPLOYMENT - # Working		
None	245	33 %
One	339	45
Two	138	18
Three or More	30	4
TOTAL	752	100 %

DESIRED ECONOMIC BASE ACTIVITY		
Yes	344	77 %
No	105	23

TYPE ECONOMIC ACTIVITY MOST DESIRED	
Water Resource Marketing	18 %
Indian Museum	14
Amusement Park	13
Resort	12
Light Industry	11
Heavy Industry	9
Crafts	7
Other	5
Agriculture	5
Restaurant	4
Animal Husbandry	1
None	1
TOTAL	100

AGE HEAD OF HOUSEHOLD		
18 - 24	50	7 %
25 - 34	208	27
35 - 44	221	29
45 - 54	116	15
55 - 64	81	11
65 - 74	54	7
75 & Over	27	4
TOTAL	757	100 %

LENGTH OF TIME RESPONDENT		
Less than 1 year	145	19 %
1 - 5 years	149	19
5 - 10 years	101	13
10 - 20 years	135	17
20 - 30 years	67	9
More than 30 years	177	23
TOTAL	774	100 %

LEVEL OF EDUCATION		
Some Grade School	47	7 %
Grade School	33	5
Some High School	209	31
High School Graduate	168	24
Some College	184	27
College Graduate	11	2
Some Graduate School	12	2
Graduate Degree	19	2
TOTAL	683	100 %

INCOME LEVEL		
$ 5,000. & below	197	29 %
5,001 - 10,000	170	25
10,001 - 15,000	111	16
15,001 - 20,000	73	11
20,001 - 25,000	49	7
25,001 - 30,000	40	6
30,001 - 40,000	29	4
40,001 - 50,000	17	2
over 50,000	4	.005

EMPLOYMENT CATEGORIES		
Professional/Tech	130	22 %
Admin/Managers	43	7
Sales	26	4
Craftsmen	22	4
Clerical	41	7
Construction/Labor	113	19
Farm Labor	92	16
Personal Household	32	6
Other Labor or Service	88	15
TOTAL	587	100 %

CONDITIONS ON RESERVATION		
Improved	269	36 %
Remained the Same	325	44
Worsened	151	20
TOTAL	745	100 %

III. Proposed Changes in Medicare Payment Policies

The President's budget calls for cuts in payments to teaching hospitals and in capital cost reimbursement. In addition, the Inspector General of the Department of Health and Human Services ("HHS") called for elimination of the disproportionate share adjustment in a report issued last May. I would like to address these issues and the problems that would result if such changes were made.

A. Medical Education Adjustments

The President's budget contains proposals to reduce the Medicare payment adjustment for the indirect costs of graduate medical education. The adjustment would be reduced from 7.65% to 4.05%.

The General Accounting Office ("GAO") also has opined that the indirect medical education adjustment is too high (GAO/HRD-89-33). The GAO recommends that, without changes to the cost factors considered in calculating the adjustment, the indirect medical education adjustment should be set at 5.09%, if the costs are measured more accurately.

The Association of American Medical Colleges ("AAMC") recently analyzed the impact of the various types of PPS payments on hospital margins and the effect of cutting the indirect medical education adjustment from 7.65% to 4.05%, as proposed by the President. The AAMC found that the DRG rate does not recognize important differences in hospital costs, including the range of services offered by teaching hospitals and the socioeconomic mix of their patients. According to AAMC's analysis, a 50% reduction in the indirect medical education adjustment would reduce average PPS margins of teaching hospitals from 1% to -10%, not counting the disproportionate share adjustment, or -5.5% counting the disproportionate share adjustment.

Moreover, the impact of reductions in indirect medical education payments may be exacerbated by changes in the reimbursement methodology for the direct costs of medical education. Since the Health Care Financing Administration only recently issued proposed regulations for implementing this statutory change, the impact of the new payment methodology is not yet clear. Thus, to avoid the potential for totally unmanageable financial distress, it may be wise to postpone any changes in the reimbursement for indirect medical education costs.

In summary, reaching a truly accurate figure with respect to the indirect costs of graduate medical education involves a complex interaction of variables (such as case-mix, location, and the effects of outlier and disproportionate share payments). I will not venture to suggest that a specific figure is correct or incorrect. Rather, I will assert simply this: urban public hospitals cannot withstand cuts in medical education payments without compensating adjustments elsewhere in the Medicare reimbursement scheme.

B. Capital Payments

In OBRA 1987, Congress reduced payments for capital costs by 12% (below costs) as of January 1, 1988, and by 15% in FY 1989. In FY 1991 the Secretary of Health and Human Services will be required to incorporate capital payments into the prospective payment system.

The President has proposed that capital costs be reduced more drastically in FY 1990 -- to 25% below costs. While the impact of these reductions would not as great as that resulting from cuts in indirect medical education reimbursement, they are still significant for urban public hospitals.

NAPH members and other metropolitan public hospitals have special concerns regarding capital cost reimbursement because the average age of their plants is significantly greater than that of other hospitals. Capital improvements, including modernization of equipment, have been unaffordable to most urban public hospitals. Because of their relatively low level of privately-insured patients, as noted above, such hospitals are uniquely reliant on governmental payors in their effort to gain access to capital. Yet it is this very same reliance that makes it so important that needed renovations and improvements be made. At this point, the situation is getting desperate for many safety net facilities. Thus, I urge you to keep the situation of these hospitals in mind when considering any changes in the reimbursement for capital costs. In addition, we will be asking the Congress later this year to consider taking positive steps to assist such safety net hospitals in gaining access to capital.

C. The Disproportionate Share Adjustment

As I mentioned above, the disproportionate share adjustment has been essential for our nation's urban public hospitals, and has been an effective way to target Medicare funds where they are needed most. From the information presented earlier, there should be no doubt that these hospitals are deserving of this adjustment, in support of the vital role they play in caring for the nation's low income elderly and other poor, and in providing essential specialized services to all citizens. Nevertheless, the HHS Inspector General issued a report in May of 1988, claiming that the disproportionate share adjustment was not necessary and should not be renewed upon its expiration date, which was then set at 1990.

NAPH is pleased that your subcommittee subsequently took the lead in convincing the Congress to reaffirm the importance and validity of the disproportionate share adjustment by extending the expiration date until October 1, 1995. Although the Congress thus already has rejected the Inspector General's recommendation, by extending the adjustment, I would like to take this opportunity to point out some serious flaws in the Inspector General's report.

First, in conducting the audit on which his conclusions are based, the Inspector General used data that were seriously out of date. Second, unlike ProPAC, the Congressional Budget Office, and other observers, the Inspector General looked only at Medicare costs and expenditures -- and not at all at the costs associated with Medicaid and uninsured patients, which are an essential part of the disproportionate share adjustment equation.

IV. Illustrations

In this section of my testimony, I would like to illustrate the general characteristics and observations set out above by describing the current situation of three particular urban safety net hospitals.

A. James A. Jackson Memorial Hospital, Miami

Jackson Memorial Hospital (JMH) is a 1371 bed public hospital owned by Dade County and operated by the Dade County Public Health Trust. The Trust also owns and operates two other inpatient facilities with an additional 115 beds, bringing the total to 1486 beds in all. JMH is the largest hospital in the Southeastern United States. It serves as a regional tertiary referral center, for insured and uninsured patients alike, for a wide range of medical specialties. Those include perinatal care, high risk obstetrics, severe burns, spinal cord injuries, cancer and transplantation. JMH has 96 specialty outpatient clinics and numerous special care centers around its campus, and serves as the only Level I Trauma Center in South Florida.

During FY 1989, JMH anticipates providing over 463,000 inpatient days of hospital care, over 278,000 outpatient visits, and over 155,000 emergency room visits. JMH's emergency room and outpatient centers will experience 43% of all of the outpatient and ER visits in the Miami metropolitan area. Over sixty percent (60.8%) of JMH's inpatient days and 63.9% of its outpatient and emergency room visits will be for uninsured or low-income patients.

JMH's inpatient admissions continue to increase at a rate of 7-10% per year, and its occupancy rate continues to rise as well. This year, JMH anticipates operating at a 92.6% occupancy rate overall. Some services, however, will be far higher than that. JMH anticipates more than 16,000 live births this year (over 44 per day), with the result that its newborn occupancy rate is expected to be over 119%. JMH's AIDS inpatient population continues to increase dramatically -- from 18 inpatients on any given day in 1985 to over 55 today.

JMH's work force consists of over 6500 FTE employees, making it the seventh largest employer in Dade County. Its medical education program is also one of the largest in the country. Next year, it will train 415 of its own medical house staff, and an additional 270 house staff associated with other schools and facilities.

In 1987, the last full year for which we have complete figures, Jackson Memorial Hospital had net patient service revenues of approximately $284 million. Seventeen percent (17%) of JMH's 1987 revenues were from Medicare, 16% from Medicaid, and 25% from private insurance. By far the largest proportion, or 42%, came from direct state and local governmental subsidies. Over 33.7% of JMH's total budget -- an amount greater than its Medicare and Medicaid revenues combined -- was provided by Dade County alone.

JMH's total operating expenses in 1987 were approximately $305 million, resulting in a patient services operating deficit of $21 million, or nearly -7%. Fortunately, through a variety of other small sources of non-operating revenue and emergency state grants totaling nearly $10 million, JMH was able to end 1987 with an overall surplus of $530,000. This represented a "profit margin," if you would like to call it that, of less than two-tenths of one percent, after taking into account the significant direct state and local subsidy. Without this subsidy, JMH's negative margin would have been well over -30%!

Medicare patients account for a substantial proportion of JMH's "insured" patients, and therefore is an important third- party revenue stream. Yet while its Medicare patient load has continued to expand each year, its total Medicare reimbursement has actually been reduced in real dollars each year -- from $32.8 million in 1985 to $29.7 million in 1987.

In particular, JMH has seen a dramatic reduction in the proportion of its gross Medicare revenues covered by Medicare payments. In 1985, Medicare paid Jackson Memorial 71% of its gross Medicare charges. By 1987, that proportion was reduced to 66%; it is estimated to be just 63% in 1988 and 58% in 1989. By way of contrast, even Medicaid will pay JMH about 73% of gross charges this year -- and Florida is by no means a generous Medicaid payor.

This reduction in the adequacy of Medicare funding has occurred despite the fact that JMH's Medicare disproportionate share hospital adjustment increased from zero in 1985 to approximately $1.8 million in 1987. The problem is, the indirect medical education adjustment fell during that period by nearly $1 million; program-wide increases were held well below the rate of inflation; and capital cost reimbursement also has been substantially reduced.

B. Boston City Hospital

Boston City Hospital (BCH) is a 468-bed tertiary care facility founded in 1864. Its occupancy rate presently is 77.8%. BCH is a Level I Trauma Center and also offers special expertise in high-risk obstetrical care, pediatric infectious diseases, and connective tissue disorders. The Hospital contains a neonatal intensive care unit which treats one-fourth of all the children born at the hospital. In addition, BCH serves as major teaching center for nurses and other allied health professionals, as well as physicians. This year, BCH will train approximately 230 residents.

BCH will have net operating revenue of $130,738,000 in 1989, and will provide $63.3 million, or about 44% of its total utilization, in care for uninsured indigent patients (including bad debt and uncompensated care). Medicare is expected to contribute 18% of the hospital's revenues, or $25,913,000, in FY 1989, including a disproportionate share adjustment of $1.7 million. In FY 1990, BCH expects to receive over $3.13 million for indirect medical education costs and another $3 million for direct medical education costs.

Despite these payments, BCH has been losing money since the mid-1980s. In FY 1989, it is expected to lose $13.2 million, of which over $1 million can be attributed to the losses incurred in treating Medicare patients. In FY 1990, BCH expects to lose close to $1.7 million in treating Medicare patients (assuming a PPS update of 2%).

If the proposed cuts in the indirect medical education adjustment are enacted, Boston City Hospital estimates a loss of approximately $1.6 million. In addition, BCH estimates losing over half a million dollars due to implementation of the new methodology in reimbursement for direct medical education expenses.

BCH currently projects a FY 1989 operating margin of -9.2%. Accounting for the estimated cuts in direct, and proposed cuts in indirect medical education payments, the Hospital's total operating margin would be -10.7%.

C. Harbor/UCLA Medical Center, Los Angeles

Harbor/UCLA Medical Center, part of the Los Angeles County Department of Health Services, is an urban teaching hospital that functions as the facility of last resort for the uninsured and under-insured population in the southwestern region of Los Angeles County. It has 553 licensed beds, and will train 350 medical residents this year. Harbor/UCLA's average daily census in 1988-89 is expected to be 485 (for an occupancy rate of 87.7%). Harbor is a certified Level I Trauma Center and is designated as a Pediatric Critical Care Center. It is a major provider of public mental health care, and is also known for its heart surgery and renal transplant programs. In 1987-88, Harbor provided over $93 million in unreimbursed charity care. Most of its Medicare patients are low-income and are also eligible for Medi-Cal (California's Medicaid program).

In 1987-88, Harbor's net revenues came primarily from Medi-Cal payments (30.7%) and state and local government subsidies (47.2%). Medicare payments constituted just 6.5% of its net revenues, or $11.5 million. Harbor's operating expenses for 1987-88 were $180 million, while its net operating revenues were only $176.6 million, leaving a negative operating margin of -$3.4 million or -2%. If local and non-Medicaid state subsidies are not counted, the operating margin was -27.37%.

Harbor projects that in 1988-89, its net Medicare revenues will total approximately $12.5 million, of which approximately $2.4 million will be for its indirect medical education adjustment, and $1.6 million will be its disproportionate share adjustment.

A reduction in the indirect teaching adjustment to 4.05% would translate into a loss of close to half a million dollars. Thus, while Medicare is not one of Harbor's largest payors, its Medicare revenues -- and particularly the teaching and disproportionate share adjustments -- are nonetheless essential to its continued survival.

In summary, you can see from these illustrations that the nation's safety net hospitals are operating "at the margin." In fact, most have negative operating margins, and I could have substituted public hospitals in Memphis, Cincinnati, Houston, Denver, Oakland, or a dozen other major urban areas and described basically the same situations. While we recognize that the budget deficit constrains the ability of Congress to address all of the needs of safety net hospitals, we urge you to give extra consideration to the financial situation of these hospitals in formulating your budget recommendations.

While we acknowledge that the subcommittee is only beginning to consider your legislative agenda for the new Congress, we believe it is important to set concrete goals early on if they are to be achieved in an era in which the budget deficit is such an overwhelming concern. We therefore reiterate our applause for Chairman Stark and your cosponsors for already introducing legislation to address such critical concerns as direct support for "safety net" hospitals, the crisis in trauma care, and the adequacy of Medicaid payments. In the forthcoming budget debate, we urge you to pay careful attention to the impact of the indirect teaching and disproportionate share hospital adjustments on our most vulnerable safety net hospitals. We further urge your continued careful consideration of legislation to mandate minimum health benefits, and we expect also to invite your continued attention this year to narrower, but equally important, issues such as access to capital, Medicare bad debt payments, outliers, and outpatient surgery. Finally, you should be aware that, in the forthcoming debate over the most appropriate methods of reducing the deficit -- with all due respect to the campaign promises of President Bush -- you will have the support of at least this segment of the industry if you choose to raise taxes to offset at least a part of the deficit.

Chairman STARK. Thank you very much.

Mr. Van Hook.

STATEMENT OF ROBERT T. VAN HOOK, EXECUTIVE DIRECTOR, NATIONAL RURAL HEALTH ASSOCIATION

Mr. VAN HOOK. Mr. Chairman, I am Bob Van Hook. I am executive director of the National Rural Health Association, and I really appreciate the opportunity to testify on behalf of NRHA members on our perspectives on rural hospitals.

Rural America is a place of great variety. Rural communities like the hospitals have serve them vary greatly. Rural Georgia is quite different from rural Montana, and its hospitals usually reflect those differences even though our health policies do not do it as well as they could.

Despite those differences, most rural areas share a set of common problems. Failing rural economies combine with a variety of other health care system changes to place many rural hospitals in jeopardy. At the current rate of more than 40 rural hospital closures per year, well over 400, or 15 percent of the Nation's more than 2,600 rural hospitals will close in the next 10 years.

Chairman STARK. Excuse me. How many a year?

Mr. VAN HOOK. About 40. There were, I believe, 41 last year.

Chairman STARK. So, you are saying every hospital that closed last year was rural?

Mr. VAN HOOK. No, I am saying 41 rural.

Chairman STARK. That is all that was closed last year.

Mr. VAN HOOK. There were 80 total.

Chairman STARK. No, there were not. Believe me, there were not.

Mr. VAN HOOK. Seventy-nine.

Chairman STARK. Forty. Forty-one to be exact. We have the numbers, but the rest was a shell game. Some closed and some reopened, but I will get them to you later.

But if you are right, it strengthens your testimony that every hospital that closed last year was rural.

I will get you that later.

Mr. VAN HOOK. Fine, sir.

I was using the AHA data.

Chairman STARK. Be careful when you do that.

Mr. VAN HOOK. I guess I had better.

Others are projecting the closure of as many as 600 rural hospitals over the next 10 years. Obviously not all closures have bad outcomes for either the rural health care system or the people it serves.

Many closures, however, seriously compromise health care access as Medicare beneficiaries and other rural residents who have no other place for service that is within a reasonable driving time.

The question is not, "Will rural hospitals close?" or even, "Should rural hospitals close?" The questions more rightly are: Which rural hospitals will close? How will those decisions be made, and by whom, and most importantly, what services will be left in the community after the closure of the hospital?

Unfortunately, current decisions on rural hospital closures are essentially random, and the health outcome of those decisions are almost entirely ignored except by the rural communities themselves.

What is wrong with rural hospitals? I could not go home and face my members if I did not reiterate that discriminatorily low Medicare reimbursement is a major problem. But it is not the only problem facing rural hospitals. We simply cannot ignore that under PPS, urban hospitals are reimbursed an average of about 36 percent more than rural hospitals for the same service. Rural hospitals are the low-cost alternative, but not that low.

All we want is a level playing field which could be accomplished at a relatively small additional cost to the Medicare program.

I also want to mention that looking at the cost is complicated. It is complicated by the fact that rural hospitals have been underpaid for the last 5 years, so their costs are necessarily going to be lower because of those payments.

The declines in the volume of in-patient services in rural hospitals, which has been mentioned several times today, has changed the game for many rural hospitals from in-patient to out-patient services for a variety of reasons.

Rural hospitals have experienced declines in admissions of around 30 percent in this decade, about double the loss in urban hospitals.

Health personnel shortages continue to plague rural America. Most rural health care providers indicate that recruiting is harder today than it was 5 years ago. Recruiting problems exist especially for family doctors, nurses, and all other types of therapists.

Access to affordable capital is an increasing problem. Rural facilities built under the Hill-Burton program in the 1950's and 1960's are aging, and need to be replaced or remodeled.

Finally, overall cuts in the Medicare program are mass punishment for both hospitals and beneficiaries. We urge Congress not to cut Medicare. Shrinking the reimbursement pie places both beneficiaries and hospitals at jeopardy. If cuts in the Medicare program are necessary, they should carefully consider across the board cuts. We would urge you to be selective and cut programs and services that lack proven efficacy and that result in higher profit rates.

Most people, when they think of public hospitals imagine large inner city urban facilities such as Cook County Hospital in Chicago, or Truman Medical Center in my hometown, Kansas City. However, about 40 percent of all rural hospitals are public or district hospitals. Rural and inner-city hospitals are an odd couple, and share many characteristics which are outlined in my written statement.

Suffice it to say that inner-city and rural hospitals are the sole community health resources for the populations they serve. They are essentially public utilities. If they close or curtail services, their populations are essentially left without access.

While there are many similarities between rural and urban hospitals, there are also some important differences. The first is the tyranny of averages. The prospective payment system is the system based on a large number of cases, over which the cost of care is supposed to average out. Smaller rural hospitals, especially, do not have these large numbers. Therefore PPS for smaller facilities is a crap-shoot, gambling that the bad cases will not come first.

There is a high cost of maintaining critical access. The sparse populations in rural communities results in a higher standby costs for low-volume services in rural hospitals, even if the service is an essential one, such as emergency medical services.

Change hits hard. Rural hospitals' heavy reliance on Medicare as a payer makes them disproportionately vulnerable to changes in the Federal program. Every ripple in the Medicare program causes a wave in the rural hospital that makes for a very rough ride in a very small boat.

Ambulatory care is a way of life. One of the ways that rural hospitals have coped with the changes brought about by PPS and by the climbing in-patient volume has been to develop more ambulatory services. It is not all so unusual for rural hospitals to have 40 percent or more of their total revenues coming from ambulatory services.

These services are going to be greatly affected by paying for them prospectively, and I would urge your close attention to the impact of doing so. Many rural hospitals are predicting that this change alone could be the one that could halt more services than any Medicare changes today.

Rural hospitals are the low-cost, low-tech alternative to high-cost, high-tech care in the cities. We should be careful not to dispose of this alternative until we understand the relative efficacy of each alternative. Rural hospitals are not just down-sized urban models. Rural hospitals and the populations that they serve have unique essential characteristics that require different and more flexible approaches.

What else is right about rural hospitals? Well, many rural hospitals are adapting to the unprecedented changes of the last 5 years despite the many problems facing them. Rural hospitals are diversifying. They are networking, linking rural hospitals with other rurals, and rurals to urban. And they are down-sizing to adjust to lessened demand.

Rural hospitals are developing systems of care at the local level, integrating various elements of the health care system into their communities. Rural hospitals, very importantly, are developing new models of care, and are truly becoming community health centers. These models are evident in newly emerging formal experiments in Montana, California, Colorado, and Arkansas, as well as less formal models in other parts of the country.

What needs to be done? Health reimbursement policies should encourage rural hospitals to do the right thing. We need a public policy that is both consistent and flexible, and that will: first, pay all hospitals adequately and equitably regardless of their geographical location; second, develop increased local access to locally-appropriate, necessary services. Services follow payment. Pay well for organ transplants and organ transplants will proliferate. Pay well for coordinated, cost-effective care, and those services will follow as well; third, encourage new rural health care model development that does not depend on high volume of in-patient care for survival, and that retrofits rural hospitals for their new service missions; fourth, keep Medicare part A dollars in rural communities to support other vital services after the closure of the hospital, such as transportation that Mr. Anthony mentioned; and, fifth, finally, encourage affiliations that foster efficient, high-quality regionalized health services including those that link rural facilities with other rural facilities, and rural with urban.

The National Rural Health Association thanks you again for allowing us to testify, and we stand with our colleagues in the hospital industry in offering to help with these changes.

Thanks for the opportunity.

[The statement of Robert T. Van Hook follows:]

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Robert T. Van Hook, *Executive Director*

What's Right and Wrong with Rural Hospitals?

Testimony before the
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health
March 1, 1989

My name is Robert Van Hook, Executive Director of the National Rural Health Association. The National Rural Health Association is a broad-based organization representing a diverse membership, including hospitals, community and migrant health centers, nursing homes, universities and others, as well as private doctors, nurses, educators and researchers – all working together toward the common goal of improving rural health and rural health care. I appreciate the opportunity to testify on behalf of NRHA members on the current status of rural hospitals.

Rural Hospitals are in Trouble.

Rural America is a place of great variety. Rural communities, like the hospitals that serve them, vary greatly. Rural Georgia is quite different from rural Montana, and its hospitals usually reflect those differences. Despite their differences, most rural areas share a set of common problems, including:

- economic stagnation or decline;
- fewer insured people and more people less able to pay bills;
- more stress-related health problems;
- shrinking populations as rural people move to cities to find work;
- a shrinking tax base, despite an increasing demand for tax funding; and
- a greater dependence on health care as major part of the economy.

Failing rural economies combine with a variety of other health care system changes to place many rural hospitals in jeopardy. At the current rate of more than 40 rural hospital closures per year, well over 400 or 15 percent of the nation's more than 2,600 rural hospitals will close in the next ten years. Recognizing that the annual number of closures has increased annually during the 1980s, the Senate Special Committee on Aging recently cited the projection that as many as 600 rural hospitals may close in the next ten years.

Obviously, not all closures have bad outcomes for either the rural health care system or the people it serves. Many closures, however, seriously compromise the health care access of Medicare beneficiaries and other rural residents who have no other place to go for service that is within reasonable driving time. The question is not: *Will* rural hospitals close?, or even, *Should* rural hospitals close? The questions more rightly are: Which rural hospitals will close?; How will those decisions be made and by whom?; and most importantly, What services will be left in the community after the closure of the hospital? Unfortunately, decisions on rural hospital closures are essentially random, irrational decisions, and the health care outcomes of those decisions are almost entirely ignored, except by the rural communities themselves.

What's Wrong with Rural Hospitals?

I would not be able to go home and face my members if I did not reiterate that **discriminatorily low Medicare reimbursement** is a major problem, but it is not the only problem facing rural hospitals. We simply cannot ignore that under PPS, urban hospitals are reimbursed an average of about 36 percent more than rural hospitals for the same service. Rural hospitals are the low-cost alternative, but not *that* much lower.

Declines in the volume of inpatient services in rural hospitals have changed the game for many hospitals from inpatient to outpatient. Rural hospitals have experienced declines in admissions of around 30 percent in this decade – about double the loss in urban hospitals. For some smaller rural hospitals, this change has reduced their inpatient volume to below the critical numbers needed to sustain some inpatient services. It is ironic that the hospitals that most need to change are often the ones that have the fewest human and financial resources to plan and implement such changes.

Health personnel shortages continue to plague rural America. Most rural health care providers indicate that recruiting is harder today than it was five years ago. Recruiting problems exist especially for family doctors, nurses and all types of therapists. The supply of critical personnel is simply too small to meet the increasing demand at both rural and urban facilities. Because supply is short, competition for health personnel is increasing. Underpaid rural facilities are having a difficult time competing with other types of facilities and programs that have more resources, and in some cases, more desirable locations.

Access to affordable capital is an increasing problem. Rural facilities built under the Hill-Burton Program in the 1950s and 1960s are aging and need to be replaced or remodeled. Rural hospitals are in weak financial condition due to all of the above problems, and their building or remodeling programs often are not considered very "bankable." Rural people, like their urban counterparts, want attractive new facilities with the most modern equipment, and they will often drive past their rural hospital to get the amenities that they associate – rightly or wrongly – with quality care.

Overall cuts in the Medicare program is "mass punishment" for both hospitals and beneficiaries. Shrinking the reimbursement pie places both at jeopardy. It is important to note that per capita Part A and B reimbursement declines as county population density declines. Rural hospital reimbursement represents a very small piece of the Medicare Part A pie – about 10 percent when the Rural Referral Centers are excepted. This is not the place to find meaningful savings. If cuts in the Medicare program are necessary, they should be carefully considered, and hospital updates are not the place to cut. Be selective, and cut programs or services that lack proven efficacy.

Similarities Between Rural and Inner City Urban Hospitals

Most people, when they think of public hospitals, imagine large inner city urban facilities, such as Cook County in Chicago or Truman Medical Center in my home town of Kansas City. However, about 40 percent of all rural hospitals are public or district hospitals. In rural as in urban public hospitals, many "business" decisions are, in fact, "political" decisions. Change is not readily accepted in the political arena, even though the rapidly changing health care environment demands immediate adaptation.

Rural and inner city hospitals are an "odd couple," and share many characteristics:

- Inner city and rural hospitals are strapped for money and other resources to help them in adaptation.
- Inner city and rural hospitals have high proportions of uncompensated care reflecting the relative weakness of the economies in the two areas.
- Inner city and rural hospitals have small private pay bases on which to shift the cost of care for the poor.
- Inner city and rural hospitals rely heavily on public payors – Medicare and Medicaid – for their revenues, and both programs often are paying less than cost. These two payors usually combine to provide more than 50 percent of total revenues, and often the percentage is much higher.
- Inner city and rural hospitals have similar difficulties in attracting health professionals.
- Inner city and rural hospitals are the sole community health resource for the populations they serve. They are essentially public utilities. If they close or curtail services, their poplations are left without access.

What Is Different About Rural Hospitals?

While there are many similarities between urban and rural hospitals, there are also some important differences:

- **The Tyranny of Averages** The Prospective Payment System is a system based on large numbers of cases over which the cost of care is supposed to "average-out." Smaller rural hospitals especially do not have those large numbers. Therefore, PPS for smaller facilities is a crap-shoot, gambling that the "bad" cases won't come first. Were it not for these shortcomings, most rural hospitals would prefer prospective payment to retrospective payment. PPS makes a good philosophical fit with rural values, but it has significant problems in its current execution.
- **The High Cost of Maintaining Critical Access** The sparse populations in rural communities result in higher standby costs for low volume services in rural hospitals, even if the service is as essential as emergency services.
- **Change Hits Hard** Rural hospitals' heavy reliance on Medicare as a payor makes them disproportionately vulnerable to changes in the federal program. Every ripple in the Medicare program causes a wave in the rural hospital that makes for a very rough ride in a small boat. Most small businesses are not subject to such radical market changes.
- **Ambulatory Care is a Way of Life** One of the ways rural hospitals have coped with the changes brought about by PPS and by declining inpatient volume has been to develop more ambulatory services. It is not at all unusual for rural hospitals to have 40 percent or more of their total revenues coming from ambulatory services. These ambulatory services are going to be greatly affected by paying for them prospectively, and I would urge your close attention to that impact. Many rural hospitals are predicting that this change could be the one that will halt more services than any of the Medicare changes to date.
- **Generalist Personnel Needed** Rural hospitals and other rural facilities have different personnel needs than larger facilities. There is a greater need for well-trained generalists in both nursing and medicine. Because of their low volumes, rural hospitals often require more part-time personnel, and where available, multicompentency personnel play a vital role in efficiency.
- **The Low-cost/Low-tech Alternative** Rural hospitals are the low-cost, low-tech alternative to high-cost, high-tech care in the cities. We should be careful not to dispose of this alternative until we know what the relative efficacy of each alternative. Perhaps PPOs should be developed that encourage urban dwellers to seek care in less costly rural facilities.

Differences in operating systems can be either assets or liabilities. Unfortunately, in the current environment much of the uniqueness of rural hospitals tends to show up on the wrong side of the ledger. This condition could be helped by recognizing that rural hospitals are not just downsized urban models. Rural hospitals and the populations they serve have unique essential characteristics that require different and more flexible approaches.

What Else Is Right About Rural Hospitals?

Many rural hospitals are adapting to the unprecedented changes of the last five years despite the many problems facing them.

1. **Rural hospitals are diversifying** into new product lines more relevant to the populations they serve. These new services both increase access and provide a way for hospitals to spread their fixed costs.

2. **Rural hospitals are networking** for quality and efficiency along a continuum of affiliations that range from loose referral networks to cooperatives to managed systems. These networks are both rural-to-rural and rural-to-urban.

3. **Rural hospitals are developing systems of care** at the local level, integrating the various elements of the health care system in their communities. These relationships between doctors, hospitals, public health, long-term care, etc., are made in the absence of local competition in order to assure the survival of access points to care and to improve the coordination of services and to end fragmentation. It would be a shame to see concerns with fraud and abuse, that are more relevant to urban competitive markets, applied to these activities.

4. **Rural hospitals are downsizing** to adjust to inpatient volume declines and their inability to cover inpatient costs.

5. **Rural hospitals are developing new models** of care and are becoming community health facilities. These are evident in newly emerging formal experiments in Montana, California, Colorado and Arkansas, as well as other less formal models in other parts of the country.

What Needs To Be Done?

Health reimbursement policy should encourage rural hospitals to "do the right thing." We need a public policy that is both consistent and flexible, and that will:

1. **Pay all hospitals adequately and equitably** regardless of their geographic location. If the current Prospective Payment System does not work for a class of hospital, it should be modified or replaced before it forces the unplanned closure of hundreds of facilities.

2. **Develop increased local access** to locally-appropriate and necessary services. Services follow payment. Pay well for organ transplants and organ transplant services will proliferate. Pay well for coordinated, cost effective care and those services will follow, as well.

3. **Encourage new rural health care model development** that does not depend on a high volume of inpatient care for survival and that retrofits rural hospitals for their new service missions.

4. **Find ways to keep Medicare Part A dollars in rural communities** to support other vital health services after the closure of the hospital.

5. **Encourage affiliations** that foster efficient, high-quality regionalized health services, including those that link rural facilities with other rural facilities, and rural with urban.

The National Rural Health Association stands with its colleagues in the hospital industry in offering to help with these changes. Thank you for the opportunity to testify.

Mr. DONNELLY [presiding]. Thank you, Mr. Van Hook.

Our final witness is an old friend, Carol McCarthy, president of the American Hospital Association.

Please proceed.

STATEMENT OF CAROL M. McCARTHY, PH.D., PRESIDENT AMERICAN HOSPITAL ASSOCIATION

Ms. McCARTHY. Thank you very much, Mr. Donnelly, and thank you all for the invitation to be with you today on behalf of the 5,300 member hospitals of the American Hospitals Association. We sincerely appreciate it.

We have all listened to so many statistics. I am trying to think what is the best thing I can do in the short time alloted to me, and that is perhaps is to put this all into context in the year in which we stand.

You have heard Mr. Gage tell you about our public hospitals scenario that reflects many of our not-for-profit teaching hospitals as well. You have heard Mr. Van Hook speak about rural America. You have heard Dr. Dobson explain the statistics, and I can give you AHA's. They will mirror all of the other statistics. They will not be off that much.

They are all consistent. They are consistent in one way, and that is that where we stand now, after years of the prospective payment system, there is no such thing as "we against they" anymore. The damage, the hurt, exists across all facilities.

If in fact we do not accept the President's budget—if in fact we allow reimbursement as it is currently set forth in law to proceed, we will still have in this country two-thirds of all hospitals suffering a loss when they treat a Medicare beneficiary—half of those hospitals suffering a loss of 10 percent or more; a third of those hospitals suffering a loss of 20 percent or more; and average patient revenue margins of minus 8 to minus 9 percent.

It is across all size categories. Interestingly enough, hospitals between 200 and 400 beds will show the worst margins overall. Our hospitals under 50 beds, of course, are likely to have and continue to have the greatest numbers of deficits of over 25 percent.

It is across all types of ownership, and whether teaching or nonteaching—some of our teaching hospitals now have deficits that far exceed our nonteaching hospitals. In 1 year, between 1987 and 1988, teaching hospital margins dropped 67 percent. And even if you were to accept the ProPAC recommendation of a 14 percent cut in indirect medical education, given the status of the hospitals and where they will be in 1990—that would lead to a very tenuous future, indeed.

Even with disproportionate share payments, hospitals are losing money and even with large outlier payments. Another interesting fact—the data show that the larger the number of outliers the more susceptible the hospital is to heavy losses.

So whether it is large urban or small urban, or rural, and whatever region of the country we are in, the situation in 1990 is significantly bad for too many facilities before the Bush budget cuts.

There has to be, at a minimum, payment for capital—full capital; there has to be at a minimum, a maintenance of indirect med-ed and at a minimum a full-market basket update. That is not going to improve any of the statistics I just shared with you, but at least it is going to stop a situation that is bad from getting worse.

The American Hospital Association has worked with hospitals of all sizes and types and ownerships and regions to try to come up with a proposal that is worth your consideration as a way to put the hospital system back on a sound footing in this country.

And it really has two general approaches. One is to improve the adequacy, and the second is to improve the equity, and I would be pleased to go through those with you.

We think it is important for you to address both adequacy and equity now, even if it is no more than to pass the kind of legislation that puts the foundation in place so we can make the specific moves over time.

And in the interim time, if we could fully support the changes, it is time now for an appeals process. Because the losses are in all categories and in all locations and all sizes, it is time for an appeals process so at least a decision can be made about the need to help the individual institutions.

It is also time for a rural hospital opt-out. For rural hospitals with fewer than 50 beds, if they were given an option to either continue in this system—which as you heard so often today requires large numbers—or get out, at least you would have given them that option.

It is time as well to remove Medicare from the influence of Gramm-Rudman measures and from the unified budget of the United States because we desperately need to make Medicare policy, based on what is good Medicare health policy and not on what is good budget policy.

And the American Hospital Association is truly committed to working with you as we take up each of these issues: to see if we cannot let a prospective payment system realize its promise for cost-effective care delivery, but realize that promise without having too many facilities where nurses cannot get to the bedside in a fast enough time because we cannot hire enough; without having too many hospitals that have to cut back on the hours of service, or cut back on even offering a costly service such as trauma care or burn care or neo-natal care; without having closures in access vulnerable areas; and without cost-shifting too much to other payers.

Thank you very much.

[The statement of Carol McCarthy follows:]

Statement
# of the
American Hospital Association
before the
Subcommittee on Health
# of the
Committee on Ways and Means
# of the
United States House of Representatives
on
Fiscal Year 1990 Budget Issues Relating to Medicare's Hospital Insurance Program

March 1, 1989

Summary

In recent years, hospitals have absorbed much of the burden of federal deficit reduction. Further cuts of this magnitude are a direct threat to hospitals' ability to maintain access to the high quality care Medicare beneficiaries and others expect and deserve.

In FY 1990, two-thirds of all hospitals will lose money providing services to Medicare beneficiaries--with nearly one-half incurring deficits of 10 percent or more and almost 30 percent incurring losses of 20 percent or more. The reasons for these burgeoning losses are continuing federal budget cuts and increases in costs beyond the control of prudent hospital managers.

The AHA believes there should be no further cuts in Medicare payments to hospitals: hospitals should receive a full market basket update for FY 1990 with no cuts in indirect medical education or capital. Further, additional funds are needed to improve the adequacy and equity of PPS payments.

Specifically, we feel payments should be recalculated periodically based on current cost data. A single base rate should be established, adjusted for differences both in the kinds of patients admitted to hospitals and in the prices hospitals must pay for resources.

Mr. Chairman, I am Carol M. McCarthy, Ph.D., J.D., president of the American Hospital Association (AHA). On behalf of its more than 5,300 member hospitals, the AHA is pleased to submit this statement on issues related to Fiscal Year (FY) 1990 budget proposals affecting the Medicare hospital insurance program.

Mr. Chairman, to put my comments in perspective, I would like to open by pointing out that Medicare prospective payment system (PPS) reforms enacted in 1983 have already resulted in savings of billions of dollars for Medicare and the federal government. Not only has the rate of increase in inpatient hospital expenditures been sharply curtailed, but hospitals have also contributed disproportionately to the effort to reduce the size of the federal deficit. Reductions of this magnitude cannot be sustained over time without some corresponding erosion of quality or access to care. Cuts in the Medicare budget proposed by the Bush Administration further threaten both.

Medicare Hospital Payment Outlays

Exclusive of the benefit expansions in the Medicare catastrophic coverage law, Medicare spending for inpatient hospital care under current law is projected to increase about 11 percent in FY 1990. But that 11 percent growth is the result of the following four factors: inflation in the prices of goods and services used by hospitals; increases in the size and average age of the Medicare beneficiary population; a more seriously ill patient population; and expiration of certain payment reductions in effect during FY 1989. Specifically, the Administration's budget assumes a hospital market basket increase of 4.7 percent; population growth and aging account for a 3.2 percent growth in outlays; the Medicare case-mix index (a measure of the complexity of Medicare patients admitted to hospitals) is projected to rise about 1 percent; and the expiration of the current 15 percent reduction in capital payments will increase per-case payments 1.9 percent.

All the factors cited above are beyond the control of hospitals; nevertheless, the Administration's budget essentially requires hospitals to absorb the bulk of their impact. If the Administration's Medicare budget proposals are adopted, outlays for inpatient hospital care will rise less than 5 percent, only marginally above the assumed rate of increase in the hospital market basket. That means that, despite a growing beneficiary population that is aging, more seriously ill, and more difficult to treat, the nation's hospitals would be expected to provide care next year at an aggregate expenditure level just about equal to this year's after controlling for inflation.

Unfortunately, the nation's hospitals simply do not have reserves equal to such a task. The effects of such reductions would be to threaten directly both access to and quality of hospital care. Some hospitals would be forced to close their doors entirely, others to shift the burden to other payers, and still others to eliminate certain specialized but very costly services, reduce the hours of operation for some departments, lengthen the time patients must wait for nurses, or take other actions that compromise the availability and quality of care that we, as Americans, have come to expect of our health care system.

Impact of Cuts

Our current projection is that in FY 1990, payments by Medicare to the average hospital will fall short of costs by between 8 and 9 percent. Nearly two-thirds of all hospitals will lose money caring for Medicare patients, nearly half will incur deficits of 10 percent or more, and nearly 30 percent will incur losses of 20 percent or more. These margins and percentages are practically the same for urban hospitals, rural hospitals, teaching hospitals, and nonteaching hospitals. It is against this background that the Administration's proposals to reduce hospital payments $3.4 billion must be weighed.

There are two primary reasons for falling hospital margins: payment reductions in every budget reconciliation bill enacted by Congress since PPS' inception, and rising costs. The "bottom line" is that the combination of less-than-inflation updates in prices and higher-than-market-basket increases in costs has caused payments by Medicare to fall far short of the cost of caring for Medicare patients.

In addition, indirect medical education (IME) payments have been curtailed sharply. Since 1984, changes in the indirect medical education payment formula have cut these payments between 30 and 40 percent, depending on the level of involvement of the hospitals in graduate medical education. These reductions translate into reductions in overall PPS-related payments to teaching hospitals of between 2 and 12 percent. Although teaching hospitals were singled out by the Inspector General of the Department of Health and Human Services in the first year of PPS as having Medicare operating margins substantially above the average, that situation no longer prevails. Teaching hospitals are, on average, no better off than hospitals generally, and some are even experiencing larger deficits than non-teaching hospitals.

Any further reduction in the indirect adjustment would jeopardize the financial status of many teaching hospitals whose IME payments comprise an average 20 percent of their total Medicare payments. Moreover, while margins have declined for all hospitals in FY 1988, teaching hospital margins have declined an average 67 percent from FY 1987 to FY 1988. Reductions in the adjustment for teaching hospitals would force them to make substantive changes in the services they offer and the resources they employ.

Further exacerbating the economic pressures on hospitals are a variety of other deficit reduction measures enacted over the years, measures that have affected everything from capital to outpatient payment.

Causes of Rising Hospital Costs

Many have argued that hospital margins would not have plummeted if hospitals had kept their costs under control. But there are legitimate reasons for hospital cost increases, which are directly associated with the very real demand for patient care and services and are beyond the control of hospital managers. Health care is a unique product, and neither the provider nor the recipient is prepared to compromise on quality. Simply put, we all want and believe we deserve the best care possible. More specifically, there are several reasons for hospital costs rising above the Health Care Financing Administration (HCFA) market basket:

-- First, hospital costs are rising more rapidly than the Medicare market basket because the market basket fails to reflect accurately the increase in costs of the most important resource used to care for patients--the hospital's staff. Many types of hospital personnel are in short supply--particularly nurses, who typically comprise about one-half of a hospital's staff. As a result, hospitals must provide more rapidly increasing wages and benefits than offered to employees in other sectors of the economy. Nevertheless, Medicare bases its measure of "inflation" on changes in wages in other parts of the "service sector." The use of such price proxies in the market basket may understate the rate of hospital input price inflation by 2 to 4 percentage points.

-- Second, hospitals are treating more severely ill patients. The formula used by Medicare to pay for care generally reflects the cost impact of changes in the kinds of patients treated in hospitals. However, within DRGs, patients admitted to hospitals today are more seriously ill and require more complex treatment than patients admitted in 1984. Many "short stay" procedures have been moved outside the hospital. Treating more severely ill patients in the hospital requires a higher skill mix of employees. It is reasonable to project that this phenomenon accounts for an additional 2 to 4 percentage point increase in costs beyond inflation.

-- Last, advances in medical technology, which offer patients the hope of receiving less-invasive treatment and thus reduce pain and risk, significantly add to the per-case cost of treating hospital patients. The demand for more sophisticated tests and procedures has increased dramatically as consumers become aware of scientific advances. These costs are not always reflected in the measure of inflation used by Medicare.

Despite these pressures, hospitals have made efforts to increase productivity and contain costs. In fact, hospital productivity has increased significantly since the inception of PPS. Specifically, the number of full-time equivalent staff per adjusted admission has remained constant since 1984, despite increases in the acuity level of patients in both inpatient and outpatient settings. And hospitals continue to make every effort to improve efficiency in both the use of services and delivery of care. The evidence for these efforts is found in shorter lengths of stay and successful efforts to hold the line on increased staffing despite the admission of more patients needing more intensive care.

RECOMMENDATIONS

General Comments

Many individuals and entities involved in health care policy continue to debate the future direction of the health care system. As a practical matter, insofar as Medicare hospital payment policy is concerned, improvement of PPS appears to be the only option in the short-term, or for FY 1990.

As you know, development of PPS was a major reform enacted in the early 1980s with the support of the hospital field. Since then, hospital payments have been significantly reduced, largely because of the deficit reduction imperative. While various studies document the magnitude of these reductions, we believe it is generally fair to conclude that hospitals have indeed contributed more than their fair share toward efforts to reduce the federal deficit.

This pattern continues under President Bush. Assuming the Bush budget conforms with the final Reagan budget, for FY 1990 it will recommend Medicare hospital payment policy changes that would result in reductions of $3.4 billion below current law estimates. Given that the Bush Administration recommends total budget cuts of $21.9 billion, hospital payment reductions would constitute over 15.5 percent of this total while Medicare hospital payments compromise just 5.4 percent of total federal outlays.

At the same time, implementation of PPS and its transition to national payment rates have resulted in a redistribution of Medicare hospital payments. When this system was created, it was widely acknowledged that there would be problems down the road, problems inherent in the reshuffling of any payment system involving the distribution of tens of billions of dollars.

Unfortunately, as a result of the deficit dilemma, efforts to address these problems have been instituted in a budget-neutral manner, which often means robbing Peter to pay Paul. For example, urban hospital payments have been reduced to increase rural hospital rates, and teaching hospital payments have been reduced to increase rates paid to hospitals serving large numbers of low-income patients. While these changes were effected more easily in a budget-neutral manner in the early years of PPS when most hospitals experienced positive operating margins, we simply cannot continue to operate under these circumstances when nearly two-thirds of the hospitals in the nation are losing money every time a Medicare beneficiary walks through their doors.

In short, we believe that there should be no further cuts in Medicare payments to hospitals. Moreover, it is our view that additional funds need to be provided to improve the adequacy and equity of payments under PPS.

Therefore, for FY 1990 we urge that proposed reductions in both capital payments and the indirect medical education adjustment be rejected. Moreover, we believe that all hospitals should receive, at a minimum, a full marketbasket update to their PPS rates.

Specific Proposals

Adequacy of Payment

Over time, Medicare payments to hospitals must bear a reasonable relationship to costs incurred in providing needed medical care to patients. To achieve this goal, AHA recommends that payments be recalculated periodically based on current cost data. The Association believes that such a recalculation should include a recognition of costs associated with providing care to the medically indigent, as well as an appropriate level of funding to underwrite the risk experienced by hospitals under a fixed per-case payment system.

Rates should be recalculated every four years using an expanded definition of the cost of caring for Medicare patients. Between these quadrennial recalculations, prices should be updated by the percentage increase in the price of goods and services that hospitals must purchase to provide care. For providers exempt from PPS, a more timely means of adjusting payment limits of individual providers for changes in case mix and treatment is needed.

This recommendation is a significant change in the Association's position. While we have categorically rejected previous attempts to "rebase" the system that were driven solely by deficit reduction demands, our current position is based on a recognition that an objective standard is needed for judging whether PPS rates are adequate. Since the Prospective Payment Assessment Commission (ProPAC) and Congress have implicitly relied on hospital operating margins as the standard for judging adequacy, adopting this position would simply make that standard explicit.

Such an approach would also provide hospitals with payment predictability--a fundamental principle that was promised when PPS was instituted--to allow hospital managers to undertake financial planning necessary to operate their institutions efficiently.

Because payments to individual hospitals would not be linked to their own costs but to aggregate or systemwide costs, incentives to improve efficiency would be preserved.

Furthermore, to ensure that Medicare payment policy issues are decided on their merits, AHA believes that the program should be exempted and removed from the Gramm-Rudman-Hollings budget deficit measures and removed from the consolidated budget of the United States.

Mr. Chairman, we recognize that you have taken a leadership role by introducing legislation in the last Congress that addresses this matter. We stand ready to assist you in any way in regard to this very important issue.

Equity Improvements

Mr. Chairman, you and your subcommittee have been particularly sensitive to equity problems experienced by hospitals under PPS and have led the way in efforts to address them and make the system fairer. In fact nearly every reconciliation bill has included provisions that attempt to improve equity. These range from addressing the problems experienced by hospitals that serve high volumes of low-income individuals to the special problems faced by rural hospitals. We view our recommendations as a systematic approach to build on the efforts undertaken by you and your subcommittee in this regard.

Our equity proposal includes four basic elements:

First, we recommend establishment of a single base rate, adjusted for differences in the kinds of patients admitted to hospitals and for differences in the prices hospitals must pay for resources.

However, our support for this approach has two contingencies:

- the single base rate should not be implemented without refined adjustments for patient mix and resource prices that are described below; and
- movement to a single-rate system must be accompanied by a "hold-harmless" provision that protects hospitals from a reduction in payment resulting from movement to the single rate. In other words, we cannot support efforts to achieve a base rate simply by cutting urban hospital payments to increase rural hospital payments.

Second, the diagnosis-related group (DRG) system has been widely criticized for its failure to capture the "severity" of a patient's condition, and considerable resources have been expended in developing "severity measurement systems" to either replace the DRG system or be used in concert with it. While we believe that a comprehensive severity adjustment should eventually be implemented, none of the current systems has reached a state of development and validation that would warrant its adoption. Until such a system can be embraced, a program of DRG refinement should be adopted. Efforts should focus on refinement of "problem" DRGs, which account for more than 1 percent of Medicare admissions and which show substantial variation in costs.

Third, PPS rates are currently adjusted only for differences in prevailing wage levels. In the long term, we believe that a comprehensive adjustment should be developed that accurately reflects prices paid by hospitals in local markets for all types of resources. While such an adjustment or index is being developed, we believe the following steps should be taken in FY 1990, or the short term:

- the existing wage index should be updated to reflect current wage levels;
- regional differences in liability insurance and energy costs should be adjusted for; and
- an exceptions or appeals process should be created to correct problems arising because of inappropriate assignment of a hospital to a local market; errors in data or in calculations; variations in resource prices within a local market that are attributable to government policies or local economic conditions; and variations in resource use that are clearly beyond the control of hospital management and medical staff.

In fact, in both the long and short term, however refined the adjustments for patient mix and resource price, an exceptions or appeals process will always be needed to take into consideration unique circumstances of individual hospitals that cause them not to fit a general rule. All routine adjustments assume that hospitals are "average" and will continue to work well for a majority of hospitals. But some hospitals will simply not fit into such a system of averages.

Fourth, given that small rural hospitals may lack the volume that is essential to a payment system based on averages, rural hospitals that operate fewer than 50 beds should be given the option to receive cost-based payments. In addition, criteria should be developed that would permit larger hospitals, including selected urban hospitals that are the sole source of care for their communities, to seek and receive an exemption from PPS.

Finally, we recommend other changes related to PPS that include refinements in payments for sole community providers and an extension of current payment policies for rural referral centers.

Conclusion

The reductions in payment that have been proposed by the Bush Administration would seriously compromise the ability of hospitals to maintain access to needed, high-quality medical care for Medicare beneficiaries. The ProPAC recommendations, while substantially more sensitive to the needs of hospitals, do not go far enough to ensure adequate and equitable payments.

Although AHA recognizes the importance of reducing the federal deficit, hospitals have already contributed disproportionately to the effort to reduce the deficit. A significant effort is needed to place PPS on a sound footing and to make the refinements in the system that will ensure adequate payment and equitable treatment both for hospitals and Medicare beneficiaries. The AHA has recommended several actions that can be taken to achieve those goals and looks forward to working with you and the subcommittee in an effort to realize the potential of prospective payment for improving access to high-quality, cost-effective medical care.

Mr. **Donnelly**. Thank you, Carol.

Could we just get to the issue of exactly how many hospitals closed last year because there are numbers floating all over the place? I have heard the number of 81.

We have the information that the real number is 44.

Could you respond to that please?

Ms. **McCarthy**. Let me do my very best for you.

As of the last day of 1988 there were 81 community hospitals that closed and 17 specialty hospitals that closed. You can get to a 40 number, however, if you look at what hospitals opened in 1988. And that figure was 44.

But it is very important to note—again 81 community hospitals closed, 17 specialties. Of the 44 hospitals that opened, the vast majority, over 80 percent of them are specialty hospitals, 19 psychiatric, 10 rehabilitation, 5 alcohol and chemical dependency hospitals, 1 other special facility and 9 general medical hospitals.

Mr. **Donnelly**. If you could provide the specifics for the record because from the information I have, using the number 81: 11 of those closed their acute care units only, 3 became PPS exempt. One was not a hospital; it was an abortion clinic. Two reopened in 1988 and two reopened in 1989 since the beginning of the calendar year. And on and on the list goes, so that the real number that closed was 44 and an additional one closed in 1989.

It seems to me when we are debating the magnitude of the effect upon the hospitals in America we really need to get the specific number, where they were, what type of institutions from the best records that you have.

Ms. **McCarthy**. We would be please to provide that to you. I would only indicate that equally as important for your attention are those hospitals that have not closed but are operating under extreme financial distress now.

Mr. **Donnelly**. Any sort of names, dates, specific facts that you have that we ought to have as we go through the process would be gratefully received.

Mrs. Johnson.

Mrs. **Johnson**. Thank you, Mr. Chairman.

I would appreciate it if you would present that information to us by State with both the closures and the openings and the nature of the hospitals, and in those instances where there was a reopening of the same physical facility that provides a different health care service. We ought to be able to agree on the facts from this matter because relative to the complexity of other issues, it is certainly modest.

[The following was subsequently received:]

American Hospital Association

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Telephone 202.638-1100
Cable Address: Amerhosp

March 22, 1989

The Honorable Fortney H. Stark, Chairman
Ways and Means Health Subcommittee
1114 Longworth House Office Building
Washington, DC 20515

Dear Mr. Chairman

Per your request at the March 1, 1989, hearing of the Ways and Means Subcommittee on Health, enclosed is the American Hospital Association's (AHA) list of community hospital closures in 1988. I respectfully ask that the list and this letter setting forth AHA's methodology for determining closures be made a part of the hearing record.

The definition of a community hospital closure and the process that AHA uses to compile its closure list have been consistent over time and are based on sound methodology. The list includes community hospitals closed as of a given date each year--December 27 in 1988. AHA considers a hospital closed when one or both of two conditions are met on that date:

- the hospital no longer provides acute inpatient care; and/or
- the hospital is no longer licensed or registered with a state.

Even if a closed hospital continues to provide outpatient, rehabilitation, or other health care services, it is still counted as a closed community hospital because it does not provide the full range of services patients expect from, and does not meet the definition of, a community hospital. In 1988, this was true of 17 of the 81 facilities on AHA's list of community hospital closures, just as similar closures would have been in past years.

AHA recognizes that many, if not most, closed hospitals hope to reopen at some point, but intent notwithstanding, because the facility has discontinued inpatient services (other than for construction or seasonal purposes) or is not licensed, AHA counts it as closed. AHA identifies community hospital closures in three ways:

- o several surveys taken each year;
- o changes in membership status that prompt direct contacts with hospitals; and
- o contacts with state hospital associations and state licensure agencies.

Occasionally, there is disagreement over a specific hospital closure, and AHA works to reconcile the discrepancy. The number of such cases is quite small. In 1988, three hospitals were involved. Each case involved a distressed hospital attempting to reorganize. After discussions with both the hospital and the state licensure agency, we concluded that the hospitals should be classified as "closed" since none appeared to be providing acute inpatient care at the end of 1988 when their status was verified. Each of these facilities appears to have succeeded in reorganizing but reopened either in the last week of 1988, after our canvas concluded, or in 1989. Should these hospitals survive through 1989 we will count them as new hospitals, unless it becomes evident that they did not actually close in 1988, in which case we will revise the 1988 closure list. In the fourth case, Cullen Women's Center in Texas, our discussions with the state licensure agency in 1988 indicated that the closure occurred in 1988. Since then, the state agency has informed us that the hospital stopped functioning as an acute inpatient hospital in late 1986. However, the state agency did not identify the hospital as closed in either 1986 or 1987 at the time of our canvas.

You should be aware that the process of identifying closures also fails to identify some hospitals that close during a year. For example, our continuing efforts to identify both new hospitals and hospital closures has already turned up three hospitals that closed in 1988 but which were not identified last year and which do not appear on the 1988 list. When we issue the closure data in 1989, we will revise the 1988 figures to reflect this new information. Such revision is our standard practice.

These individual cases simply illustrate the inherent complexity of identifying hospital closures. AHA acknowledges that the process requires judgment when an occasional case is neither black nor white, but AHA stands by its hospital closure data as accurate. Further, if the subcommittee would find it helpful for AHA to identify closed community hospitals that are offering non-acute or non-inpatient services in addition to "new" hospitals that have reopened since the previous year, the Association will attempt to do so in the future. (Closed community hospitals offering acute rehabilitation services only are already listed as "new" community hospitals; closed community hospitals offering acute psychiatric health care services only are already listed as "new" specialty service hospitals.)

To provide further context for the attached list, I would add that AHA views the collection of data, whether to document closures or other aspects of operations, with utmost seriousness and approaches that task with due diligence and absolute honesty. Hospital closure data have been collected annually since 1980. Our survey is factual, our methodology has remained consistent and thorough, and in no way have our conclusions been influenced by our policy agenda. Most data discrepancies between AHA's surveys and those conducted by others are attributable to definitional differences.

A close examination of our advocacy to protect patients from the impact of hospital payment reductions will show we have not focused disproportionately on the issue of hospital closures. Nor have closure data constituted the cornerstone of our Medicare advocacy efforts. We recognize--and publicly have emphasized--that Medicare payment shortfalls are one of many factors responsible for hospital closures. Furthermore, AHA acknowledges that some hospital closures may be appropriate but they should not result from the impact of inequities in payment systems, and they should not significantly reduce access to essential health care services in a community.

Indeed, hospital closures may not be the major threat in fiscal 1990. The best data available to the AHA indicate that, even under the current law, Medicare payments in the year ahead will fail to cover the cost of services provided to Medicare beneficiaries in two-thirds of the nation's hospitals. With such a large percentage of hospitals experiencing Medicare payment shortfalls, the more pressing problem may well be curtailed services, such as the shut down of trauma centers and emergency rooms.

I hope this discussion and attached list answer your questions, Mr. Chairman. My staff and I remain ready to provide more detail, if needed.

Sincerely

Carol M. McCarthy

Carol M. McCarthy, Ph.D., J.D.
President

Enclosure

AMERICAN HOSPITAL ASSOCIATION
COMMUNITY HOSPITAL CLOSURES 1988
(SEE ATTACHED FOOTNOTES)

STATE	HOSPITAL	CITY	BEDS	SERVICE
REGION=1				
MAINE	CASTINE COMMUNITY HOSPITAL	CASTINE	12	10
MASSACHUSETTS	BROCKLINE HOSPITAL	BROOKLINE	56	10
MASSACHUSETTS	FARREN MEMORIAL HOSPITAL	MONTAGUE	72	10
REGION=2				
NEW YORK	PARSONS HOSPITAL	FLUSHING	100	10
NEW YORK	EMMA LAING STEVENS HOSPITAL	GRANVILLE	25	10
NEW YORK	JAMESTOWN GENERAL HOSPITAL	JAMESTOWN	99	10
NEW YORK	JOHNSTOWN HOSPITAL	JOHNSTOWN	39	10
NEW JERSEY	LIVINGSTON COMMUNITY HOSPITAL	LIVINGSTON	94	10
PENNSYLVANIA	ST MARY HOSPITAL [1]	PHILADELPHIA	160	10
REGION=3				
WEST VIRGINIA	ELIZABETH C LEONARD MEM HOSP	BUCKHANNON	20	10
WEST VIRGINIA	HOLDEN HOSPITAL	HOLDEN	36	10
WEST VIRGINIA	GUTHRIE MEMORIAL HOSPITAL	HUNTINGTON	32	10
WEST VIRGINIA	WYOMING GENERAL HOSPITAL	MULLENS	25	10
WEST VIRGINIA	TUCKER COUNTY HOSPITAL	PARSONS	25	10
NORTH CAROLINA	BLACKWELDER MEMORIAL HOSPITAL	LENOIR	35	10
GEORGIA	FIRST HEALTH HEARD	FRANKLIN	29	10
FLORIDA	UNIVERSITY HOSPITAL	HOLLY HILL	97	10
REGION=4				
OHIO	NORTHEASTERN OHIO GEN HOSPITAL	MADISON	66	10
ILLINOIS	HOSPITAL OF ENGLEWOOD	CHICAGO	121	10
ILLINOIS	FRANK CUNEO MEMORIAL HOSPITAL	CHICAGO	106	10
ILLINOIS	ST ANNE'S HOSPITAL	CHICAGO	239	10
ILLINOIS	MARY THOMPSON HOSPITAL	CHICAGO	203	10
ILLINOIS	ST ANNE'S HOSPITAL-WEST [2]	NORTHLAKE	78	10
ILLINOIS	WHITE HALL HOSPITAL	WHITE HALL	30	10
MICHIGAN	ORCHARD HILLS HOSPITAL [3]	BELDING	56	10
MICHIGAN	BAY AREA MEDICAL CTR-MENOMINEE	MENOMINEE	40	10
WISCONSIN	ST ANTHONY'S FAMILY MED CTR	MILWAUKEE	303	10
WISCONSIN	NEW BERLIN MEMORIAL HOSPITAL	NEW BERLIN	82	10
WISCONSIN	BAYFIELD COUNTY MEM HOSPITAL	WASHBURN	121	10
REGION=5				
TENNESSEE	SCOTT MEMORIAL HOSPITAL	LAWRENCEBURG	64	10
TENNESSEE	JOHNSON COUNTY MEM HOSPITAL	MOUNTAIN CITY	66	10
TENNESSEE	SMYRNA HOSPITAL	SMYRNA	33	10
TENNESSEE	ST MARY'S NORTH HOSPITAL	LAKE CITY	20	10

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ALABAMA        HENRY COUNTY HOSP & NRSC HOME    ABBEVILLE      103  10
ALABAMA        COLUMBIA REGIONAL MEDICAL CTR    ANDALUSIA      137  10
ALABAMA        FIRST HEALTH COURTLAND           COURTLAND       35  10
ALABAMA        MEDICAL PARK WEST                BIRMINGHAM      50  10
ALABAMA        CHAMBERS COUNTY HOSPITAL         LAFAYETTE       38  10
ALABAMA        PERRY COMMUNITY HOSPITAL         MARION          67  10
ALABAMA        NORTH MOBILE COMM HOSPITAL       SATSUMA         38  10

---------------------------------- REGION=6 ----------------------------------

MISSOURI       LINDELL HOSPITAL                 ST_LOUIS        51  10
MISSOURI       UNIVERSITY OF HEALTH SCIENCES    KANSAS CITY    129  10
SOUTH DAKOTA   IPSWICH COMMUNITY HOSPITAL       IPSWICH         21  10

---------------------------------- REGION=7 ----------------------------------

ARKANSAS       RIVERVIEW HOSPITAL               LITTLE ROCK     50  10
ARKANSAS       WOODRUFF COUNTY HOSPITAL         MCCRORY        139  10
ARKANSAS       LEE MEMORIAL HOSPITAL            MARIANNA        25  10
LOUISIANA      FAIRVIEW HOSPITAL                BAYOU VISTA     49  10
LOUISIANA      REGENT HOSPITAL FELICIANA        CLINTON         36  10
LOUISIANA      GUEYDAN MEMORIAL HOSPITAL        GUEYDAN         21  10
LOUISIANA      TENSAS MEMORIAL HOSPITAL         NEWELLTON       30  10
LOUISIANA      PLEASANT HILL GENERAL HOSPITAL   PLEASANT HILL   30  10
OKLAHOMA       CORDELL MEMORIAL HOSPITAL        CORDELL         28  10
OKLAHOMA       E P CLAPPER MEM MEDICAL CENTER   WAYNOKA         24  10
TEXAS          BASTROP REGIONAL MED CENTER      BASTROP         25  10
TEXAS          GOLDEN PLAINS COMM HOSPITAL      BORGER          52  10
TEXAS          MILAM REGIONAL MEDICAL CENTER    CAMERON         48  10
TEXAS          COMFORT COMMUNITY HOSPITAL       COMFORT         26  10
TEXAS          GASTON EPISCOPAL HOSPITAL        DALLAS         104  10
TEXAS          FLOW MEMORIAL HOSPITAL           DENTON         111  10
TEXAS          LANDMARK MEDICAL CENTER          EL PASO        207  10
TEXAS          WHITCOMB MEMORIAL HOSPITAL       GRAND PRAIRIE    9  10
TEXAS          ROBERTSON REG MEDICAL CENTER     HEARNE          33  10
TEXAS          CULLEN WOMEN'S CENTER            HOUSTON         22  44
TEXAS          MARION COUNTY HOSPITAL           JEFFERSON       37  10
TEXAS          KIRBYVILLE COMMUNITY HOSPITAL    KIRBYVILLE      24  10
TEXAS          COMMUNITY HOSPITAL OF LUBBOCK    LUBBOCK         76  10
TEXAS          KING WILLIAM HEALTH CARE CTR     SAN ANTONIO    159  46
TEXAS          SHINER HOSPITAL                  SHINER          30  10
TEXAS          TAFT HOSPITAL DISTRICT           TAFT            70  10
TEXAS          TEAGUE GENERAL HOSPITAL          TEAGUE          28  10
TEXAS          OMNI HOSP AND MEDICAL CENTER     HOUSTON         84  10

---------------------------------- REGION=8 ----------------------------------

MONTANA        MISSION VALLEY HOSPITAL          ST IGNATIUS     29  10
IDAHO          MARSH VALLEY HOSPITAL            DOWNEY          17  10
NEW MEXICO     CUBA HOSPITAL                    CUBA             9  10
ARIZONA        PHOENIX GENERAL HOSPITAL         PHOENIX        202  10

---------------------------------- REGION=9 ----------------------------------
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Footnotes to the American Hospital Association
1988 Community Hospital Closures:

[1]St. Mary Hospital - Philadelphia, Pennsylvania

Hospital had filed for bankruptcy early, 1988. April 30, first layoffs began; layoffs were scheduled for every Friday until May 21, when hospital's doors would be shut. An injunction was filed against the hospital to keep the facility from closing. Phone contact in October indicated that the facility was still in the process of shutting down. Phone contact in late December indicated that the facility had been purchased by MSI investment group and that the facility had closed. The new facility, when reopened, will be known as Neumann Medical Center, an acute care, invester-owned facility.

[2]St. Anne's Hospital-West - Northlake, Illinois

Hospital reported to the AHA it closed as of October 1, 1988. Direct contact was made through the AHA membership department three times in 1988. Each time, the facility indicated that it was closed. Phone contact in December indicated that the hospital had been sold and renamed Leydon Community Hospital. Recommendation by state licensure department was to consider St. Anne's-West a closure, based on AHA's definition. New hospital changed control from church-operated to invester-owned facility.

[3]Orchard Hills - Belding, Michigan

In October, Orchard Hills informed AHA's membership department of its closure. Hospital was contacted in December and informed that the original owners ceased operations in October. The hospital is now operated by Metropolitan Hospital, Grand Rapids, under a lease/purchase option. In fact there are two leases; 25 beds are being leased as acute beds, another 25 beds are being leased as a detoxification and drug center.

[4]Cullen Women's Center - Dallas, Texas

Closure reported to AHA by Texas Department of Health as of 7/01/88. Facility was on AHA, Texas Hospital Association, and Texas Department of Health files as an Obstetrics and Gynecology hospital. AHA as well as the Texas Department of Health had not been informed that the hospital had been operating only as an outpatient facility for two years.

Upon further research, we have determined that inpatient services ceased at the hospital late in 1986. Therefore, this facility will now be listed as a 1986 closure.

Addendum

Additional 1988 Hospital Closures March, 1989 Update

Scranton State General Hospital - Scranton, Pennsylvania
Hospital closed 12/31/88. Verified by Pennsylvania Hospital Association and licensing agency. Lawsuit pending to reopen facility.

Turner County Hospital - Ashburn, Georgia
Closed 10/30/88. Verified by Georgia Hospital Association and by hospital. Facility hopes to reopen by July, 1989.

Dahl Memorial Hospital - Ekalaka, Montana
Acute care beds closed 6/30/88. Nursing home still open. Lost doctor and have not been able to find replacement. Have applied for special CON to operate a 'medical facility' supervised by a physician assistant. Under the new arrangement, length of stay could be no more than 96 hours. This is a type of license developed thru cooperation between the Montana licensing department and Montana Hospital Association. The institution hopes to receive CON and operate this new type of facility by 7/01/89. Hospital is still closed per administrator.

DEFINITION OF TERMS

A hospital closure is defined as the physical closure or corporate cessation of a hospital facility, or the discontinuation of inpatient medical admissions as of Dec. 31 of each year. Hospital mergers and consolidations are not included. Closure information was acquired by direct report to the American Hospital Association, and through an end-of-year canvass of each state hospital association and licensure agency. Each closure was verified by a representative of the closed hospital whenever possible.

Community hospitals include all nonfederal, short-term, general and other special hospitals whose facilities are open to the public; excluded are hospital units of institutions, psychiatric hospitals, and alcoholism and chemical dependency facilities.

Control refers to the type of organization responsible for establishing policy concerning the overall operation of the hospital. The four major categories are government, nonfederal; nongovernment, not-for-profit; investor-owned (for-profit); and government, federal.

Beds refer to the number of beds set up and staffed for use in the hospital as reported to the American Hospital Association. The number of beds shown will reflect the size of the hospital when functioning normally. The bed statistics may not reflect reductions that occurred during the months prior to closure. The tables contain breakdowns by size categories: 6 to 24 beds, 25 to 49, 50 to 99, 100 to 199, 200 to 299, 300 to 399, 400 to 499 and 500 or more.

Census regions refer to the nine geographical regions into which the U.S Department of Commerce, Bureau of the Census, divides the 50 states.

Sources: Hospital Statistics 1988 Edition, AHA Membership records and files, annual surveys, state associations, state licensure agencies and AHA Hospital Data Center files.

1988 HOSPITAL OPENINGS ON RECORD AS OF FEBRUARY 1989

	HOSPITAL NAME	CITY	BEDS	SERVICE
REGION 2				
Pennsylvania	Southwood Psychiatric Hospital	Pittsburg	36	22
Pennsylvania	Greater Pittsburg Rehab Hospital	Monroeville	85	46
Pennsylvania	UHS/Keystone Center	Chester	72	82
REGION 3				
Florida	Englewood Community Hospital	Englewood	100	10
Florida	Wellington Reg. Medical Center	West Palm Beaches	120	10
Florida	West Boca Medical Center	Boca Raton	170	10
Florida	Atlantic Shores Hospital	Daytona Beach	50	22
Florida	Capital Rehabilitation Hospital	Tallahassee	40	46
Florida	Rehab Inst. of Sarasota	Sarasota	60	46
Florida	Glenbeigh Hospital of Miami	Hialeah	100	82
Florida	Methodist Pathway Center	Jacksonville	25	82
Georgia	Hillside Hospital	Atlanta	40	22
Delaware	Meadow Wood Center	New Castle	35	22
West Virginia	Western Hills Reg. Rehab Hospital	Parkersburg	40	46
REGION 4				
Indiana	Oaklawn Hospital	Goshen	78	49
Illinois	Alcoholism Treatment Center	Winfield	52	82
Illinois	Careunit of Dupage	Downers Grove	100	82
REGION 5				
Mississippi	Parkwood Hospital	Olive Branch	40	22
Alabama	Montgomery Rehab Hospital	Montgomery	80	46
REGION 6				
Minnesota	St. John's Northeast Hospital	Maplewood	100	10
Nebraska	Richard H. Young Hospital	Kearney	80	22

	HOSPITAL NAME	CITY	BEDS	SERVICE
REGION 7				
Texas	HCA Denton Community Hospital	Denton	56	10
Texas	Trinity Valley Medical Center	Palestine	109	10
Texas	CPC Capital Hospital	Austin	92	22
Texas	Charter Hospital of Fort Worth	Fort Worth	80	22
Texas	Forest Springs Hospital	Houston	36	22
Texas	HCA Richland Hospital	North Richland Hills	73	22
Texas	River Crest Hospital	San Angelo	80	22
Texas	Stafford Meadows	Stafford	88	22
Texas	Rehab Hospital of South Texas	Corpus Christi	80	46
Texas	Rehab Inst. of San Antonio	San Antonio	108	46
Texas	Rio Vista Rehab Hospital	El Paso	80	46
Louisiana	HCA North Monroe Pavilion	Monroe	48	22
Arkansas	Fort Smith Rehab Hospital	Fort Smith	54	46
REGION 8				
Arizona	Del E Webb Memorial Hospital	Sun City West	65	10
Arizona	East Valley Camelback Hospital	Mesa	62	22
Idaho	Mountain River Hospital	Idaho Falls	40	10
Colorado	Charter Hospital of Aurora	Aurora	80	22
New Mexico	Mesilla Valley Hospital	Las Cruces	30	22
Utah	Western Rehab Institute	Sandy	86	46
REGION 9				
California	Branch Hospital	Twenty Palms	30	10
California	Christian Hospital Medical Center	Perris	38	10
California	CPC Sierra Gateway Hospital	Fresno	93	22
California	HCA Cedar Vista Hospital	Fresno	36	22

SOURCE: New hospital openings in 1988 as reported to the American Hospital Association's Division of Membership as of February 1989. If two or more hospitals merge to form a new corporate entity, the resultant corporate entity is not considered a new hospital for purposes of this list.

REGION: Region is defined as U.S. Census Division. If no openings have been reported for a state, it is not listed within the region category.

BEDS: Beds set up and staffed for use as reported to the American Hospital Association Division of Membership.

SERVICE DESCRIPTION

10 = General Medical and Surgical
11 = Hospital Unit of Institution
22 = Psychiatric
33 = Tuberculosis and Other Respiratory
44 - Obstetrics and Gynecology
45 = Eye Ear Nose and Throat
46 = Rehabilitation
47 = Orthopedic
48 = Chronic Disease
49 = Other Specialty
62 = Institute for Mental Retardation
82 = Alcoholism and Chemical Dependency
50 = Child General Medical and Surgical
61 = Child Hospital Unit of Institution
52 = Child Psychiatric
63 = Child Tuberculosis and Other Respiratory
55 = Child Eye Ear Nose and Throat
66 = Child Rehabilitation
57 = Child Orthopedic
58 = Child Chronic Disease
59 = Child Other Specialty

Mrs. JOHNSON. I would like Dr. McCarthy to talk a little about Dr. Altman's assertions that hospitals continue to upcode at a significant rate, and should not be paid for these up-coding improvements.

Ms. MCCARTHY. Finally, and just recently because we only have the preliminary data out, ProPAC and the Health Care Financing Administration jointly funded a study which was carried out by RAND just on the issue on how much of the coding changes are due to upcoding or due to changes in the severity of illness of patients.

And the study is on PPS years 3 and 4, and it shows that at most 20 percent of the coding increase is attributable to improved coding. The rest is attributable to the severity of illness.

There is a second piece that is important to keep in mind, and that is there is not a one-to-one relationship between a 1-percent increase in coding and a 1-percent increase in cost. In fact that relationship is 1 to 1½ so that for each 1-percent increase in coding or in severity of illness, the cost will go up 1½ percent.

So even if we were—and which we are not—in a situation where only two-thirds of all coding actually based on the medical record was due to more severely ill patients, you would still not have overpaid a dime because of the formula's inability to directly track cost increases.

Mrs. JOHNSON. Do you have any comment on the figures that have been quoted today in regard to those hospitals at the end of the spectrum that are enjoying a margin of profitability that is significant versus those hospitals at the other end of the spectrum that are experiencing a high loss under Medicare?

Ms. MCCARTHY. Those at the end of the spectrum experiencing the significant losses out-number those at the preferred end of the spectrum.

The set of data I have with me today is the 1990 projections which show 5 percent of hospitals with a 10 percent, if you will, excess of revenue over expense. On the other hand, we are talking about at least one third of all facilities suffering losses that exceed 20 percent.

Mrs. JOHNSON. But has your association done any analysis of those hospitals that are able to profit under Medicare? What is the nature of their services? Are they simply more efficient?

Ms. MCCARTHY. There is nothing that we have been able to identify to date that shows a strong correlation to either efficiency or inefficiency. That is, of course, one of the big challenges that we have.

It does appear to rest in part on location and on the cost of living in an area. It does appear to rest in part, for example, on Dr. Dobson's identified additions to the base payment rate. It does appear to reflect differences in patterns of practice across the United States, but there is not one single answer.

[The following was subsequently received:]

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March 21, 1989

The Honorable Nancy L. Johnson
U.S. House of Representatives
Washington, D.C. 20515-0706

Dear Representative Johnson

At the March 1, 1989 hearing of the Ways and Means Subcommittee on Health, you asked whether the American Hospital Association could furnish you with a profile of hospitals in the high and low Medicare margin categories in order to identify the characteristics that distinguish them from one another. I am pleased to furnish that information herewith and respectfully request that this letter be included in the hearing record.

For each category of hospitals grouped by range of projected FY 1990 Medicare operating margin (from the 1,289 hospitals projected to experience margins below -25 percent to the 284 hospitals projected to enjoy margins greater than +25 percent), we have examined the wage index, bed size, case mix index, disproportionate share adjustment, indirect medical education adjustment, occupancy, outlier payment percentage, and number of PPS cases for the average hospital. We have found that there is very little difference in the mean values across categories of hospitals, as the enclosed table demonstrates. In other words, there is no clear systematic relationship between each of these characteristics and the projected financial performance of hospitals under the Medicare prospective payment system.

Certain characteristics, however, are associated with a greater likelihood that a hospital will experience very low Medicare margins. Hospitals with a very low case mix index, a very small number of Medicare admissions or a very low occupancy rate (i.e., below 30 percent) are more likely than other hospitals to experience very low margins. When the issue is high Medicare margins, the picture is less clear. Certain facilities with a very high indirect medical education adjustment and a high disproportionate share adjustment do enjoy favorable Medicare margins, but too many others receiving even sizable adjustments are in difficulty. Specifically, of the nearly 200 hospitals with disproportionate share adjustments of 15 percent or more, more than half (115 hospitals) will experience losses treating Medicare beneficiaries in FY 1990. Similarly, of 176 hospitals with an indirect medical education adjustment of 20 percent or more, 95 are projected to lose under the Medicare program in FY 1990. Of course, as you know, even those teaching hospitals with positive Medicare margins are experiencing significant Medicaid and indigent care losses.

I hope this information meets your needs. Should you require further information, my staff remain ready to assist you.

Sincerely

Carol M. McCarthy

Carol M. McCarthy, Ph.D., J.D.
President

Enclosure

PROFILE OF HOSPITALS BY PROJECTED MARGIN

Hospital Characteristics	Category of Projected Margin					
	-25% or less	-25% to -10%	-10% to 0%	0% to +10%	+10% to +25%	+25% or more
Wage index	0.934	0.929	0.922	0.916	0.902	0.913
Bed size	163	193	186	165	136	148
Case mix index	1.046	1.148	1.150	1.137	1.101	1 070
Disproportionate share adjustment	1.4%	1.5%	1.5%	1.8%	1.9%	1.9%
Indirect medical education factor	1.5%	2.0%	1.9%	2.0%	1.9%	2.6%
Occupancy*	63.2%	64.4%	64.3%	65.2%	65.3%	72.8%
Outlier payments	2.7%	2.8%	2.3%	1.9%	1.5%	2.3%
PPS cases	1323	2048	1955	1803	1388	1352
Number of hospitals	1289	1350	1091	931	714	284

* Weighted by bed size of hospitals in each category.

Source: American Hospital Association projections, 1989, based on Medicare PPS Year 3 cost reports obtained from the Health Care Financing Administration.

Mrs. Johnson. Thank you. I do appreciate the testimony of the others on rural and urban hospitals. In the public hospitals, have you done any breakdowns of the percentage of the urban hospitals whose costs can be attributable to their special responsibilities? For example, for trauma centers and large emergency rooms and some of those unique aspects of the case mix of urban hospitals?

Mr. Gage. Yes, we have done quite a bit of that analysis and some of it is set out in our prepared testimony that was submitted. We can provide you with more of that information.

Certainly, a substantial part of the extra cost of operating a public hospital in an urban area does come from those specialized services and the very high volume of care provided in those units. We are talking about, in some cases, 10 and 20 times the number of outpatients, emergency room visits, trauma cases than in a private or non-safety net hospital. So in a sense, the costs are clearly associated with maintaining that kind of service.

Mrs. Johnson. Now under Medicaid, do you get anything equivalent to the disproportionate share accommodation?

Mr. Gage. There is a requirement. In fact, the basic requirement in the Medicaid program predated the Medicare requirement. It goes all the way back to 1981. Until last year, it had not been adequately implemented. About 15 States up until last year did provide some kind of disproportionate share hospital payment.

Mrs. Johnson. In other words, it is not part of the national payment system.

Mr. Gage. It is now, but the requirement is still a relatively general one. It was beefed up by the Energy and Commerce Committee last year. There now is a mandatory requirement for all States. We are just doing a survey now to see what States have done in connection with that requirement. But there is now a requirement. To a certain extent it cross-references the Medicare requirement, although it has separate characteristics unique to the Medicaid program.

Mrs. Johnson. Given the national statistics on low birth weight babies and the concentration of those kinds of infants in urban areas and under Medicaid coverage, it would be interesting to know what portion of your losses are attributable to Medicaid coverage and Medicaid's inability to accommodate for intensity, particularly in those areas. I think we need better information about that.

What I am saying is that the job we are asking urban hospitals to assume in an increasingly sophisticated medical environment is increasingly costly. Therefore, the deficit under Medicaid is an increasingly significant deficit and ought to be seen in the context of the Medicare problems.

One of the reasons we are pushing so hard as a committee and, I think, as a nation is to look more carefully at this Medicare reimbursement issue and to try and disentangle it from our own deficit problems to some degree. There is clear evidence before us that Medicaid is a budget-driven reimbursement system and grossly inadequate to the challenge that we are asking it to assume.

We have seen in some provider sectors, an almost elimination of services for Medicaid recipients. You do not have that option. So I think we need a lot better data on that matter from you. I will look at your testimony in more detail and perhaps you will get me more information as to the unique costs facing urban hospitals that makes the Medicare under-reimbursement a special burden.

Mr. GAGE. Thank you, I will be happy to get you that information. I just would comment that Medicaid under-reimbursement varies widely from State-to-State. There are States, in fact, where Medicaid is now a better payer of hospitals than the Medicare program.

Mrs. JOHNSON. That is interesting. That is surprising. Actually, I will have to pursue that in another case. But your comment does remind me that this is what I am hearing from nursing homes.

Thank you.

Chairman STARK. Mr. Van Hook, I think somewhere in your testimony I recall your suggesting that if we help the rural hospitals you would hope that we do not take it out of the hide of the urban hospitals. I can find that in here someplace, can I not?

Mr. VAN HOOK. We would certainly prefer that. The urban hospitals, as you have heard from the other panelists are not doing all that well themselves. The curve has passed and we are both in the same boat.

Chairman STARK. Mr. Gage is going to support you and say, we would like you to help the inner-city hospitals, but certainly do not beat on the poor, rural hospitals. Would you not say that as a collegial sort of a guy?

Mr. GAGE. Absolutely.

Chairman STARK. Now you both I think recognize, do you not, that if there are limited resources that have to be distributed among these that we cannot have both ends of that teeter-totter in the air at the same time? I am not suggesting anything that is new or unusual, am I?

Mr. GAGE. Not only that, Mr. Chairman. The committee has already adopted improvements, at least in the urban disproportionate hospital end, that were very, very carefully targeted last year. For example, when you remove the 15 percent cap on payments, there were really only 200 hospitals in the whole country that were butting up against that cap and that have received increased payments under that kind of fine-tuning.

Chairman STARK. Your testimony is useful. But for it to be most helpful to us, you have to help us in setting priorities. You must recognize that we cannot, as the American Hospital Association would, pay all the money to every hospital that wants it. There just is not enough there. So our job is, that we just have to set priorities.

It is very difficult to do when you have to do it for all 50 States. It is not necessarily the types of hospitals, rural versus inner-city, or teaching versus nonteaching, or profit versus nonprofit. Then you get Alabama in a contest with Oregon as to which State or which city gets the money.

That is all we really have to try and do is find a compromise here that is going to get us half the votes plus one. In the process, I think all the members would want to make sure that the beneficiaries are protected. But for people to be useful in that deliberation—to say do not reduce anybody, is a nonstarter.

Mr. **Van Hook**. Mr. Chairman, you know where this puts us. This puts us squarely on the razor blade, and it is very difficult to be there.

Chairman **Stark**. It is no fun, is it?

Mr. **Van Hook**. I know, and you have lived with that with even real consequences than I do. But I guess my response would be that there are a considerable number of those one-third of the hospitals that are losing a lot of money are rural hospitals. They just do not have very many other resources. They have raised their mill levies about as high as they can go; they have had bond issues; they have done just about everything they can. They need an infusion, and they need it quickly. I think again, the idea of access—critical hospitals, or targeting increases would be useful.

The other thing is that estimates of how much it costs to fix the differential vary quite widely. But it is a relatively small amount of money when you are talking the kind of numbers that you folks deal with all the time. It is not like it would break the Federal budget. I know you have to maintain a great deal of discipline with that. But that differential, at least in the standardized amount, is relatively small and not a lot of money.

Chairman **Stark**. The problem is that here, however, we get into some other things. This is where we need help. I have a letter from a physician in North Dakota that just arrived this morning. He talks about the fact that insurance rates are high, but he suggests this. He says it is not his fees. I believe him.

But he suggests that here you have got Fargo, with a population of 100,000 or perhaps less, with two nuclear magnetic resonance facilities, when there is not one in Winnipeg or the whole of Manitoba, for example. In North Dakota, besides the two MRI's in Fargo, there is one in Bismarck and one in Minot. Now Minot is, obviously, one of the metropolises of North Dakota, but both of the physician-owned clinics in Fargo are installing yet another radiation unit.

Some of the hospitals are going out and buying practices and physician-owned clinics to steer business in. Now somehow it seems to me that between the question of trauma centers and acute care centers, I think you would agree with me that in North Dakota, on dry roads, 25 miles is not a hellish distance for people to cover. Even in a pickup truck it is not so bad.

So that at some point, it seems to me, the rural hospitals are going to have to come together and decide which are going to be acute care centers, and which are going to be skilled nursing facilities, and which are merely going to be outpatient clinics, because part of the situation in this country is that we have 1 million hospital beds staffed—not built, but staffed beds. As we sit here talking today, 300,000 of them are empty.

I have all of these hospital administrators telling me I do not understand, but that does not raise costs. Now I do not know what they think it does. And that is every day of the year we are running—this country is running two-thirds full, or one-third empty.

Now I am not suggesting that we could run on a full tank every day. But I am suggesting that therein may be part of the problem, and that the DRG system was designed to reduce that. Nobody really likes that. That is the problem we are faced with. We could go off the DRG system. You heard the testimony this morning. We could go back to controlling everything. New York State did that very well for years, which is why they have much better costs than California.

So the help I am asking for is, do not say, do not touch any of our members, just because that is not realistic. The question is, how can we be most effective in protecting the quality and access that is most important. If we have extra money, this committee could be extremely creative in finding ways to deliver services, and new services, and take care of indigent children and a whole host of things. I have got almost 20 infant mortalities in 1,000 in my district, which is obscene. I would be more than happy to spend money on it if we had it, but we do not.

So to give us some help, you have to be willing to help us set priorities.

As for the American Hospital Association, I recognize that they cannot do that. When you represent every hospital in the country, it is very difficult to suggest that even one of your members should close. I understand that. I hate to lose a vote. But I would suggest to the Hospital Association that when they testify here, and if their testimony is to be of any use to this committee, that these numbers—it is the old child who used to call "wolf" all the time. How am I, if I am told that 81 hospitals closed, when we know that only 44 really closed, than how am I to believe that two-thirds of the hospitals will lose money? Maybe it is really only 33⅓ percent.

If you do not know the names—if you have got 5,000 members and you cannot tell me the names of the 81 members who quit last year, then I miss my guess that your staff is doing what they ought to do. How can I believe that they are incurring deficits of 10 to 30 percent when I cannot believe everybody screaming at me that they closed 81 hospitals, when in fact they probably should have closed a couple hundred? But I have to say that it sounds suspiciously like the AHA is cooking the numbers. And I have enough problems with that on competing budget estimates and everything else. I am sorry, but it is——

Ms. McCarthy. Mr. Chairman, if I may?

Chairman Stark. Yes.

Ms. McCarthy. I would not cook a number for you. I would be pleased to get you all of the information that is behind those closure data and to get it to you as promptly as I possibly can out of Chicago, giving to you as well the facilities which opened last year and the supporting background information.

Further, I just also think it important to say that the American Hospital Association recognizes that the prospective payment program is not here to keep every hospital operating. When we talk about closures that are of concern, we try very hard to focus in on those when we are talking about an access-vulnerable area.

Chairman Stark. Let us assume for a minute that your staff could have misled you. But let us talk about the cuts in Medicare payments. Now was there a cut in payments to hospitals in 1989?

Ms. McCarthy. There was a——

Chairman Stark. Yes or no.

Ms. McCarthy. There was a reduction in the planned expenditures.

Chairman STARK. No, that is not the question. Would you listen just for a moment, please, to my question? In 1989, was there a cut in Medicare payments to hospitals, yes or no?

Ms. McCARTHY. An absolute cut, no.

Chairman STARK. In 1988, was there a cut or an increase in the total dollars paid by Medicare to hospitals in this country?

Ms. McCARTHY. There has been, as you know, an increase in the total dollars in the PPS program.

Chairman STARK. In every year in the past 10, I believe; is that not correct?

Ms. McCARTHY. Unfortunately, there has also been an increase in the cost of caring for the patients.

Chairman STARK. But that is not what I asked, because your testimony says, "there be no further cuts in Medicare payments." That is what I am suggesting to you is misleading. You are flimflamming us and the public with these numbers. Now if you want us to pay any attention to your testimony, which is getting difficult to do, do not kid us. Do not come out with this public relations poppycock when it cannot be believed. That does your association no good and it certainly is of no use to the committee.

Ms. McCARTHY. Mr. Chairman, the testimony speaks to no cuts from the amounts set forth in current law. That is the reason for the verbiage. It was certainly not meant to mislead you.

Chairman STARK. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Mr. Gage, Dr. Altman earlier indicated that figures can reflect a 40 percent excess of cost of urban hospitals versus rural hospitals, and that is made up of wages, sicker patients and indigent care. Are there any other factors that contribute to that?

Mr. GAGE. I think you have to look at the services being provided and the intensity of those services, and the discussion here earlier of reorganization of potential services in rural areas with hospitals perhaps converting into some other use, such as an ambulatory care facility. I think the services provided are much less intense in most—certainly not all—rural hospitals. I think there are experiments underway in some parts of the country where rural hospitals, in fact, serve as formal feeders, in effect, transferring the most sick patients on a regular basis to the urban centers. I think Mr. Anthony referred to that earlier as well.

Clearly, when you provide care to sicker patients and you provide a broader range of services, including tertiary as opposed to primary or secondary services, you are going to have a lot more costs of all kinds, not just staffing and personnel, but equipment and the size and scope of the facility itself.

Mr. COYNE. So it is logical to include these very sick patients who came from the rural areas and receive care in the urban areas, when in determining the differential?

Mr. GAGE. I certainly think it accounts for the differential in cost. It also, for the most part, is good medicine.

Mr. COYNE. Other testimony that Dr. Altman gave indicated that of the hospitals that closed in urban areas, many of them or most of them were less than 200 beds. He went on to comment that maybe part of the reason for that was there was another hospital very close by and it would not be that much of an inconvenience in service for that hospital to be shutting down. Do you find that to be the case?

Mr. GAGE. I think in the few instances where I am aware of a hospital closing down in an urban area recently, there have been a wide range of factors and the circumstances have differed substantially. I think the biggest problem is letting the marketplace alone decide which hospital is going to close and which one is going to stay open. There is no question that in many parts of the country, we do not need as many hospitals or as many hospital beds as we currently have.

The nature of inpatient care is changing dramatically right now, with hospital inpatient services in urban areas much more sharply focused on much sicker patients, and with many different kinds of treatment facilities and outpatient settings being provided for other patients.

One of the things that you are seeing in the end of the industry that I represent—Boston City Hospital is a good example of this—is a downsizing in the number of inpatient beds. Boston City's new proposed capital expenditure plan, I think, includes a downsizing of at least 100 beds from their current level, if not more. I think that those are all very positive trends.

As to whether all hospitals that close do so for the right reasons, I would think that is clearly not the case. Philadelphia General is a good example of that, and the fact that the rest of the industry in Philadelphia is having a very hard time coping right now with the level of increase in uncompensated care and the inadequate reimbursement of the Medicaid program and the increasing number of uninsured Pennsylvania patients.

Mr. COYNE. Ms. McCarthy, you mentioned that we should be concerned about the 81, or 44 hospitals or whatever it might have been that closed last year, and about those that could potentially close soon. Do you have a figure that you would like to cite on that?

Ms. MCCARTHY. It is for that reason that we were emphasizing the really deep margin data. When we do have one-third of all hospitals losing 20 percent on Medicare alone, that is when you know the results you are going to see are going to look very like what has happened in Los Angeles where we have had a closure of so many of our trauma hospitals; what is happening in Chicago, not only with trauma closures but emergency room backups that are terrible—almost as bad as some of those in New York City.

That is when you begin to see the neonatal programs stopped, and the costly burn care, the things you can no longer afford to offer if you want to stay as a facility servicing your community. That is where the tough decisions get made, where the rubber hits the road. Where you cannot afford to hire the nurses you need; where you close down units of care that are important in a community, because one bed is not the same as another hospital bed.

A bed in an intensive care unit is not the same as a bed out on the floor. If you do not have those ICU nurses and you do not have the money to pay it, you shut down that ICU unit, even though there is another bed and it is one block away, or 4 blocks away, or 14 blocks away, it is not the same as the one that is closed.

That is the kind of stress the system is under. That is why it will continue. It is going to continue even if we did not have any cut-backs from the current services. It is going to continue. We are just saying, if you cut back as well, there will be some truly, truly significant problems.

Mr. COYNE. But currently you cannot be precise about the number of hospitals?

Ms. MCCARTHY. I can give you the numbers of facilities with those kinds of losses across the boards, and the numbers of facilities with those kinds of losses within Medicare itself. I cannot tell you specifically which services would go first because that is always an individual hospital decision, and depends upon the location and the particular strain that the facility is under.

Mr. COYNE. Thank you.

Mr. DONNELLY [presiding]. Mr. Gage, I was pleased that you mentioned the situation at BCH because you use it as an example in your testimony. It is a very old, inefficient physical plant that adds tremendous amounts to the cost of operating the hospital. Hopefully, if the administration in Massachusetts approves, we can put together a facility that makes some more sense, both in delivery of services and in cost effectiveness.

But Mr. Van Hook, let me just ask you a question. Did you say in your testimony that you are asking the committee to exempt rural hospitals from the PPS system?

Mr. VAN HOOK. No, sir.

Mr. DONNELLY. Rural hospitals of 50 beds or less?

Ms. MCCARTHY. The American Hospital Association is suggesting that that be an option, Mr. Donnelly.

Mr. VAN HOOK. I think we would probably support that too, as an option. We have some serious concerns about how that would be administered too. The pie is not going to change size and might not change much shape under that option.

So philosophically, prospective payment makes a lot of—has a good fit with rural values. Rural guys are pretty chintzy administrators. That is part of the reason why they are getting hurt because in 1981 they were running little small, mom-and-pop operations and relatively efficiently. They did not think that they really needed to load up their cost in 1989 so that they could take advantage of the new system.

But I think there is a good fit with prospective payment. They like it. They would like it as an option. But when it cripples them and when it does not pay adequately, it gets close to cost, then they have got to look for something else. I think, given the fact that we have been talking today about access critical and remove access facilities, that may be a way to do it. Maybe we ought to have some sort of access adjustment that would give an adjustment for those access-critical hospitals under PPS.

Mr. DONNELLY. What I am asking is, you would be satisfied if we kept the urban-rural differential and exempted out from PPS rural hospitals with 50 beds or less?

Mr. VAN HOOK. Our option is to deal with the urban-rural differential, is what our recommendation is.

Mr. DONNELLY. Also.

Mr. VAN HOOK. Yes. First and foremost. Then, if there are other hospitals that need to be opted out, then we opt out. I am sure the under-25 bed hospitals have almost no business in PPS.

Mr. Donnelly. Dr. McCarthy, are only rural hospitals under 50 beds the only members of your organization that want to opt out of PPS?

Ms. McCarthy. I am sure a large number of them might want to, particularly in view of the margin data. Let me step back a bit and say, in the long term, certainly the American Hospital Association believes you should not pay a hospital based on where it is located. That is not a good enough reason for making a difference in the price you pay. So, we do favor the elimination of the differential.

We are saying, at the time that you eliminate it and move to do it, we have to do two other things. We must recognize the severity of illness of the patients that are treated. In addition, we have got to find a way to recognize legitimate differences in resource price inputs over which facilities do not have any control. However we draw the market, we have got to recognize those or we are constantly asking our people to accept a payment that will never be adequate.

For the opt-out, the small, rural facilities are faced with living under an averaging system. As we have heard so frequently this morning, if you do not have that type of volume, you really cannot afford to take the averages as they come.

In addition, however, the AHA would suggest that we give some look to criteria that might, in fact, also apply to an inner-city facility or some other facility that would be the sole community provider in an area. There again, too, if it is an important facility to have for access, then you may also want to extend to them the opportunity to opt out of this particular system.

Mr. Donnelly. I have one final question. I think you are aware, Dr. McCarthy, that I have filed legislation that would deny to hospitals that refuse to accept for care or treatment Medicaid patients, certain benefits under the Medicare program and certain benefits under the Tax Code; that is, the use of tax-free bonds. Has the AHA taken a position on that legislation, pro or con?

Ms. McCarthy. Hospitals—I am sorry, Mr. Donnelly—that fail to?

Mr. Donnelly. To accept for treatment Medicaid patients.

Ms. McCarthy. Our hospitals are Medicaid participants.

Mr. Donnelly. There are hospitals in this country that have not accepted and do not accept Medicaid patients. I have filed legislation that would prohibit those hospitals that refuse to accept Medicaid patients—the poorest of the poor in America—from taking advantage of certain benefits under the Medicare program and under the tax law; that is, the use of tax-free bonds.

If you have not had an opportunity to look at the legislation, I would like you and your organization to look at it and forward to me some statement of support or opposition or comment on the legislation.

Ms. McCarthy. We will do that. As you know, even in the shorter than I had hoped time I spent in Massachusetts, it was so obvious we had some significant problems, particularly with obstetrics and taking care of Medicaid patients. But one of the things that I would just ask you to consider as you look at this is not whether or not we should require every facility, every physician, every provider to give the service if the price gets too low that they cannot even afford to do it. Of course, that is exactly what was happening with our physicians in the Medicaid program in Massachusetts.

So we have to get the payment somewhere up there before we mandate that people give it away, or I do not think we are addressing the problem at its roots. But I would be very, very pleased to take a look at the legislation.

Mr. DONNELLY. What I would hope, from my perspective, is that every individual and every professional in the health care field would deliver service and treatment to any individual in the United States irrespective of their ability to pay. I think that ought to be a basic premise on which the profession looks at its role. But maybe we come from different points.

Ms. MCCARTHY. I certainly do not think that we come from——

Mr. DONNELLY. I do not ignore the Government or the private insurer's responsibility to provide funds necessary to adequately compensate those that provide that care. But overriding the financial issue, I think, is the moral issue. Let me leave it at that.

Ms. MCCARTHY. I would just go even farther and say, certainly if the issue is emergency services, I do not think that even if there is a financial issue——

Mr. DONNELLY. There ought not to be.

Ms. MCCARTHY [continuing]. There is never a time that should be an issue. If we are talking about services in general, I only share with you the concern that does exist in certain areas of the country that if you had to give all that anybody said they ever needed and it did not matter how fairly the costs were recognized, that the facilities fear they are not going to be there to give anything to anybody.

Mr. DONNELLY. Carol, I do not want to get in a debate with you. But all my legislative initiative says—and I know your people have seen it and I hope you will take a look at it—if these institutions are going to receive a subsidy from the taxpayer through the use of tax-free bonds for their renovation or expansion, that as collateral to receiving that subsidy they ought to treat people in this country who are Medicaid-eligible—the poorest of the poor.

Now granted, from their perspective, they might not be receiving the reimbursement that they think that they are financially due. However, they ask no questions of the cost when they applied for the tax-free bond to build the institution. So please look at it.

Ms. MCCARTHY. I will, indeed.

[The following was subsequently received:]

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March 20, 1989

Honorable Brian Donnelly
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Donnelly

At the March 1 hearing before the House Ways and Means health subcommittee, you asked for the American Hospital Association's (AHA) position on H.R. 157, the Health Care Providers Responsibility to the Community Act. Care for the medically indigent is a high priority issue for the AHA and its members, and therefore I would like to take this opportunity to expand my response to this question.

H.R. 157 would require hospitals and nursing homes to have a provider agreement with the state Medicaid agency as a condition for access to tax-exempt financing and receipt of certain Medicare funds. Unless a hospital established such an agreement, it would face the following consequences:

(1) Hospitals Taxed as an Unrelated Business. A not-for-profit hospital seeking to issue, or at any time use proceeds from, a tax-exempt bond for inpatient services would be considered to be engaging in "unrelated business" activity as specified under the Internal Revenue Service Code. Accordingly, income generated by the hospital for inpatient services during any year in which a Medicaid provider agreement is not in effect would be subject to the unrelated business income tax. In addition, interest expenses associated with servicing the tax-exempt bond debt would not be considered deductible expenses for calculating unrelated taxable income.

(2) Denial of Payment for Medical Education and Capital Costs. Failing to establish a Medicaid provider agreement would result in the denial of Medicare reimbursement for direct and indirect medical education costs and inpatient capital-related costs. There is no indication in the bill of the time period for which hospitals could be denied these payments.

The problem of care for the medically indigent clearly has reached crisis proportions, calling for strong and serious steps. AHA shares your concerns on this issue, and therefore strongly supports the goals of H.R. 157. We are prepared to support passage of this legislation if our concerns, outlined below, about specific provisions of the bill are addressed.

First, your bill should be considered in conjunction with Representative Stark's legislation, H.R. 751, to assure equitable payment for hospital services by the Medicaid program. His bill would mandate that states pay no less than ninety percent of what Medicare would have paid for similar cases.

Medical indigence is a complex and difficult problem, and solving it will require addressing the underlying reasons for access problems: inadequate private and public insurance coverage, rising poverty levels, inadequate reimbursement rates in public programs, and fiscal constraints of federal and state governments. Care for the poor is an integral part of the hospital mission, and our members have responded to recent declines in health insurance by providing greater and greater amounts of uncompensated care each year, even in the face of changes in public and private payer practices which make the financing of such care more and more difficult.

In 1987, hospitals provided uncompensated care costing $8.8 billion, or 5.8 percent of total costs, up from $3.5 billion, or 4.6 percent of total costs in 1980. In addition, hospitals in most states have also been subsidizing care to Medicaid patients, in the face of continuing declines in reimbursement rates relative to cost. The Stark legislation will take a step toward reversing this trend and ensuring equitable payment for hospital services. To mandate that hospitals provide Medicaid services without addressing the payment issue ignores the root problem.

Second, we also have some concerns that H.R. 157 as written could have some unintended consequences. In particular, we would suggest that additional attention and consideration be given to several issues:

(1) Compatibility with Current Law on Unrelated Business. The existing statute (Section 150 (b) of the Internal Revenue Code) pertaining to unrelated business activity by tax-exempt organizations contains its own legal tests and criteria (e.g., relatedness of activity to hospital's exempt purpose, the relative significance of the activity to entire operation of the hospital) that apparently would be subsumed by the provisions of this bill. Not-for-profit hospitals are tax-exempt because they meet the federal standard for tax-exemption, which has as its basis the provision of care and other benefits to the entire community, not just a single class of patients. Under the statute, income from trade or business uses of facilities

that are inconsistent with the non-profit organization's exempt purposes can be taxed. It is unreasonable to define non-participation in Medicaid as so inconsistent with a hospital's basic purposes that the fair rental value of the entire facility should be treated as unrelated business income.

(2) Retroactive Application of Provisions. Although the bill would authorize the application of sanctions to future hospital activity alone, hospital experience with the Hill-Burton program raises a concern that there could be subsequent attempts to apply these provisions retroactively, or to retroactively expand the nature of the obligation attached to tax-exempt financing. For this reason, if the bill were to move forward we would urge the inclusion of language to protect against such an application.

(3) Exemptions. There are a few hospitals for whom establishment of a Medicaid provider agreement would make no sense. Because the federal Medicaid program does not reimburse for psychiatric care to patients between the ages of 22 and 64, for example, a psychiatric hospital primarily serving adults may anticipate no Medicaid patients and therefore may not need a Medicaid provider agreement. The bill should include some provision for these few cases.

(4) Procedural Protections. Termination of a provider agreement could occur for reasons beyond the control of the hospital, yet H.R. 157 would automatically impose sanctions on the hospital regardless of who terminates the agreement and for what reasons. If the bill goes forward, we suggest that it be modified to apply only to those cases in which the provider terminates the agreement. Moreover, AHA believes that any bill which entails sanctions on hospitals must have an appeal process. No sanction should be applied until a final decision is made on the propriety of the termination through an appropriate appeal process.

Given the current omnipresence of Medicaid provider agreements, the bill in its present form would not have a significant impact on most of our members. Hospitals already have strong economic reasons to have Medicaid provider agreements. Without a provider agreement, hospitals are not able to receive reimbursement for any Medicaid patients, including patients treated on an emergency basis. For this reason, virtually all hospitals already have provider agreements in place.

Direct data on hospital provider agreements are unavailable, but the omnipresence of such agreements can be inferred from AHA's annual survey data. On the 1987 AHA Annual Survey, for example, all but 34 of the 3,737 community hospitals providing admissions or revenue data reported some Medicaid admissions or revenue (and therefore, of necessity, the presence of a provider agreement).

Even with the remaining 34, the lack of reported Medicaid revenues may be a function of geography, state contracting mechanisms, or hospital specialty rather than an indication that no provider agreement is in place. A provider agreement simply sets some of the conditions for serving and being reimbursed for Medicaid patients, regardless of the volume of such care in any particular year. In states with selective contracting, for example, hospitals without winning bids may see few or no Medicaid patients but will still have a provider agreement.

Moreover, there already are in place much stronger laws and regulations requiring hospital participation in Medicaid. Over two-thirds of the nation's not-for-profit hospitals, for example, are already required to provide care to Medicaid patients as part of their community service obligation under the Hill-Burton program.

However, in introducing the bill, you stated for the record that you intended to amend the current bill so that sanctions can be applied to a wide range of problems, including hospital "discouragement" of Medicaid patients and the uninsured, patient "dumping, and "premature discharge" of Medicaid patients. These are all issues of concern to AHA as well as other groups, but we do not believe that conditions and sanctions outlined in H.R. 157 would be an appropriate vehicle for solving these broader social and financial problems. To do so would entail violating the current very straightforward purpose and function of provider agreements.

Instead, it would convert them into open-ended contracts, in which hospitals would have to assume undefined responsibility for a complex and massive social problem as a condition for qualifying for tax-exempt financing and certain Medicare payments. Such a scenario would be particularly troublesome in light of the fact that Medicaid reimbursement rates in many states already are below levels adequate to assure access and meet the costs of efficiently and economically operated facilities. For this reason, our concerns about the bill would multiply if it were amended along the lines suggested in your remarks.

In summary, while we support and strongly concur with the intent of H.R. 157, we have concerns about specific provisions of the bill that should be addressed before we can support enactment of the bill. Further, enactment of the bill should be contingent upon enactment of H.R. 751, or similar legislation to ensure adequate payment by Medicaid for hospital services. We appreciate the opportunity to comment on this proposed legislation, and would welcome the opportunity to work with you further on fashioning a comprehensive solution to the crisis of care for the indigent. If you have any additonal questions or would like to discuss our comments further, please feel free to contact us.

Sincerely

Carol McCarthy, Ph.D., J.D.
President

Mr. Donnelly. Certain members of this committee feel very strongly about that on grounds of principle.

Mr. Moody.

Mr. Moody. Thank you. Ms. McCarthy, I was at another hearing so I did not hear your initial testimony nor that of Berman and Dobson. But I have been reading it while I have been sitting up here. I am particularly intrigued by the testimony by Mr. Berman and Mr. Dobson, which I assume you heard, that points out this inherent problem with DRG's in that hospital-service marketplaces are very location specific. There is not one national market, but they are very much local markets. The DRG's do not come anywhere near to recognizing that phenomena.

Would you agree with their analysis?

Ms. McCarthy. I think the data show that as we moved into that national rate and as it affects all facilities, that you begin to see huge differences in margins across hospitals of all types, sizes and locations, and that it suggests that a national rate does not take into account some very important cost differences that individual facilities experience.

It is one of the reasons when we first discussed the prospective payment program that the AHA was talking about a blended rate: Only going to that national rate on particular diagnoses where, in fact, costs tended to converge across the United States, and staying much more institution—specific on diagnoses that varied so widely. But at that time that was considered too complicated.

Mr. Moody. I understand your point there. But I want to just pin you down on one issue; a more narrowly focused question. Would you agree with the Berman and Dobson analysis that these are very much local markets? The health care market is very much local. That a national system is inevitably going to miss the mark.

Ms. McCarthy. I think that largely labor expenses tend to be in a local market. We have had great difficulty finding how you draw or redraw the line, Mr. Moody. But we know that they do, in fact, vary from one local market to another.

On the other hand, in certain instances, for example, nursing, we have had occasions when a hospital in—you could almost say there is a national rate, where a hospital in Connecticut recruits a nurse from Middle America or the Far West.

If it is a nonprofessional we are talking about, the secretarial support staff, that is a very local market. If we are talking about the professional nurse, it is much broader than that very local market. Where it is and how you draw the line, as I say, is very difficult.

Mr. Moody. I guess I am having a hard time getting my point across.

Ms. McCarthy. I am sorry.

Mr. Moody. You are answering a different question than the one I am asking. Of course, there are national uniformities. If you are buying something in a national market, we know that the price will be roughly the same wherever you are. The thrust of the Berman-Dobson analysis is that there are some important elements that are not nationally purchased but are locally purchased, and that it is the cost of the marginal supplier in a given locality which is the market clearing price.

You do not quarrel with the Dobson-Berman analysis, I assume, but you were going off in a different direction. I just want to ask you if you agree with your analysis.

Ms. McCarthy. I do agree that for the most part there is more of a local rather than a national market, yes.

Mr. Moody. Fine. Now my question is this, having laid that predicate. What would you think of a system, instead of a DRG system, where HCFA went to a community and said to each hospital, what is your best price for procedure, A, B, C, D et cetera? How much is an appendectomy? How much is this, how much is that? And each hospital came in with their bid.

Say one hospital will do appendicitis for $800, another does it for $899, another does it for $903. HCFA then picks the $800 number of that hospital. They say, "We will pay any hospital in Cincinnati or Milwaukee or Boston, that amount for an appendectomy because there is at least one hospital in the area that will do it for that price."

What would you think of that proposal?

Ms. McCarthy. I think I would at least have a little bit of concern for the Medicare beneficiary. You do not know, for example, that the beneficiary is going to have sufficient access. If you take a price at $800 and there is not sufficient capacity to meet the beneficiaries needs for that DRG treatment in that area.

Other facilities, while you might given them that challenge, might truly be unable to provide that service at that price, and therefore, cannot enter the market to serve the Medicare beneficiary.

Mr. Moody. Let me just interrupt to say that, what hospitals offer to do it at may not be, in fact, the price they could all do it at because we know that bids do not necessarily go down to rock bottom. But in fact, an institution in that community facing those local costs and the same national costs as the hospital a block away or a mile away, would be presumed to be in is the same kind of market using the Berman-Dobson analysis and therefore in a position to offer an appendictomy for approximately the same amount of money.

Ms. McCarthy. I have not heard Mr. Berman's analysis before today. I can only say that it seemed when he was testifying that he made a basic assumption. That was that one hospital is exactly like another is exactly like another. Therefore, if I have 7 or 9 or 12 hospitals in an area, if I hit the 7th, I have hit the hospital at the margin.

The difficulty with that is not all hospitals offer the same services, they do not necessarily equate with one another, and you can raise some very significant access problems—if you just count up the numbers and pick the hospital at the margin and say, that is all we want to reimburse for the care of Medicare patients—access problems for the beneficiary.

Mr. Moody. He does not assume that hospitals are all the same.

Ms. McCarthy. I have not had an opportunity to study his suggestion.

Mr. Moody. I would appreciate having any comments from your association on this proposal that I just asked you about.

Ms. McCarthy. I would be pleased to submit them.

Mr. **Moody**. Thank you.

Mr. **Donnelly**. Ladies and gentlemen, thank you. Carol, you can forward to us the information on the closed hospitals?

Ms. **McCarthy**. I will do that.

Mr. **Donnelly**. Names, date, place and type?

Ms. **McCarthy**. I will do my 100 percent very best.

Mr. **Donnelly**. Thank you.

[The information of Ms. McCarthy follows:]

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April 14, 1989

The Honorable Jim Moody
U.S. House of Representatives
1019 Longworth Building
Washington, DC 20515

Dear Representative Moody

During hearings before the House Ways and Means Committee's Subcommittee on Health on March 1 regarding Medicare hospital payment budget issues for Fiscal Year 1990, you raised the subject of Medicare contracting for care with providers on the basis of competitive bidding procedures, but time did not permit me to respond fully to your question. We have given the matter further consideration and would like to share with you some of the American Hospital Association's thoughts and concerns about competitive bidding and selective contracting. We believe that such proposals should not be adopted at the present time because of the concerns identified below.

First, the government and the hospital community are still trying to adjust to the prospective payment system (PPS), the most dramatic change in Medicare payment policy since the enactment of the program in 1965. We have yet to fully assimilate and evaluate that new system, much less perfect it. Stability and predictability would be at great risk if we again engage in a massive change and try to graft a new competitive bidding system on top of PPS. Such an effort would create significant further redistributional effects, disrupting planning and posing significant financial risks to very vulnerable institutions. At a time when there is a pressing need to take action on several critical reform proposals to make PPS more adequate and fair, the AHA would be deeply concerned about the potential for distraction that a dramatic new change in payment methodology would pose.

Second, the purpose--achieving savings in payments to hospitals under Medicare--has already been accomplished. The primary objective of moving to a competitive bidding system appears to be program savings. If this is the case, then we would argue that there is already in place in PPS a cost-containment mechanism that has reduced substantially the rate of growth in hospital payments under Medicare. Thus, competitive bidding would appear to solve a spending problem which has already been addressed--so much so that we now estimate that two-thirds of our hospitals will lose money treating Medicare patients next year.

Third, beyond cost containment objectives, we do not readily see that competitive bidding for Medicare services would improve the access or quality of services for beneficiaries--objectives that we believe are equally important. We assume that a competitive bidding process would reduce the current number of Medicare providers resulting in some adverse impact on beneficiary access. Yet, absent quality of care criteria, the process would provide no assurances that an appropriate basis had been used for provider selection.

Fourth, beneficiaries can already voluntarily choose selective systems. A degree of selective contracting is already available on a risk basis for Medicare beneficiaries through the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) which authorizes Medicare use of health maintenance organizations and competitive medical plans. Those plans selectively contract for services for their enrollees from specific hospitals and providers, and offer their services to beneficiaries as an alternative to the traditional Medicare package. Beneficiaries who choose to receive services through such arrangements--and about one million have enrolled in TEFRA plans--can do so today, on a voluntary basis. To the extent that those models prove useful to beneficiaries over time, enrollment can be expected to grow. However, it would not appear to be appropriate to force millions of additional beneficiaries into selective provider models.

Fifth, numerous definitional questions remain that raise important policy choices. For example, how would the bidding process be designed? One option would be a negotiation process between individual providers and Medicare contractors. Alternatively, Medicare could issue requests-for-proposals (RFPs) and ask interested providers to respond. A key policy question is whether all providers would be allowed to participate at a negotiated rate or only designated ones. Lastly, how would physicians without privileges at a contracting hospital gain access for their patients?

There are other issues as well concerning the scope of services subject to negotiation. Would the unit of payment be diagnosis-related groups (DRGs) or would services be re-packaged to include pre-admission and post-acute services and professional fees? If only selected services are to be subject to bids, how would they be identified and by whom? To the extent that the negotiation concentrated on services that typically provide positive operating margins, it would exacerbate the problems hospitals face in financing services that are unprofitable such as burn centers, trauma services, and the like. Such cross-subsidies are already constrained with the growing prospect that some communities will lose access to these vital services.

Other areas of concern relate to beneficiary choice and related financial responsibility. Could beneficiaries elect services from providers without contracts, and if so, would such freedom be accompanied by increased financial liability? We believe these issues pose serious problems for the design of a competitive bidding plan.

Indeed, the experience of selective contracting under Medicaid is mixed and itself gives rise to concern. Two states--Illinois and California--have engaged in statewide selective contracting for hospital services through Medicaid waivers. In both cases, the states claim significant annual savings for inpatient hospital care under Medicaid beneficiaries. However, the data show that these states pay hospitals about two-thirds of the costs of providing care to Medicaid patients. Thus, the savings associated with the program simply derive from one more approach to paying less than costs.

For example, California's Medical Assistance Commission's Five Year Anniversary Annual Report documents savings of more than $1 billion over five years, but goes on to note that "the savings achieved in the state budget have had a very direct effect on hospital financial positions." Perhaps most important in the California and Illinois experience has been the impact of concentrating Medicaid patients in institutions that are underfinanced and heavily dependent on inadequate Medicaid rates. These are often the very institutions, many of them publicly sponsored, that have a strong commitment to serving the poor and those patients without any health insurance coverage.

Nor has the negotiating and bidding process in these states produced the give and take that negotiations must entail in order to sustain the process over the long-term. Instead, the state maintains the advantage at a negotiating table which is far from level, and we see little opportunity for more open negotiations for Medicare given a deficit-driven federal government. Finally, selective contracting has generally been limited to urban areas because of the unique problems of rural areas. Thus, it does not solve--and if applied may even exacerbate--the pressing rural health care problems confronting us.

It is vitally important to recognize that competitive bidding and selective contracting under Medicare would produce far more dramatic distributional consequences than under Medicaid.

Medicare accounts for, on average, about 27 percent of total spending for hospital care--three times the volume of services financed under Medicaid. Thus, selecting only certain hospitals for Medicare contracting is likely to result in large volume shifts, and raises the specter of Medicare beneficiaries being concentrated in certain hospitals, with younger patients cared for in others. We do not find that to be an appropriate outcome.

In view of these problems, competitive bidding or selective contracting for hospitals services under Medicare does not now appear to be a viable option. We would, of course, be pleased to review this information with you in more detail, and to answer any questions you may.

Sincerely,

Carol M. McCarthy

Carol M. McCarthy, Ph.D., J.D.
President

Mr. **Donnelly**. The hearing is adjourned.

[Whereupon, at 2:24 p.m., the subcommittee hearing was concluded.]

[Submissions for the record follow:]

STATEMENT OF THE AmHS INSTITUTE, JAMES L. SCOTT, PRESIDENT

Mr. Chairman, the AmHS Institute, representing the largest network of nonprofit multi-hospital systems in the nation, would like to submit for the record our comments regarding the Fiscal Year 1990 budget issues relating to hospital payments under Part A of the Medicare program.

As the Committee is well aware, each year during this decade, the Medicare program has been subjected to substantial budgetary reductions. A comparison of data from the 1982 and 1988 Reports of the Trustees of the Health Insurance Trust Fund documents that Medicare payments to hospitals have been reduced by over $53 billion from the 1982 expenditure projections.

The AmHS Institute representing the more than 1,000 not-for-profit healthcare facilities in 43 states and Washington, D.C. which comprise the American Healthcare Systems, strongly believes that continuation of these budget driven policies puts our nation's hospitals at severe financial risk. It will not be possible to cut Medicare hospital payments by an additional $3 billion, as proposed in the Bush Administration's Fiscal Year 1990 budget, without adversely affecting both the quality and accessibility of hospital care in many areas of the country. We urge the Congress to reject the Medicare hospital payment reductions included in the new Administration's budget.

In considering this recommendation it is important to examine the cumulative effect of: 1) recent reductions in Medicare payments for hospital services, 2) reductions in Medicaid payments for hospital services, 3) increasing competitive pressures in the private market resulting in less ability to shift costs, and 4) the increasing burden of providing services to those unable to pay.

MEDICARE CUTS

The magnitude of recent Medicare hospital payment reductions is staggering. Substantial cuts in Medicare Part A expenditures were included in the Omnibus Reconciliation Acts for Fiscal Years 1987, 1988, and 1989. Congressionally mandated Medicare reductions comprised 36 percent of the savings in the Fiscal Year 1988 budget, even though Medicare accounts for only nine percent of federal outlays.

Increases in the hospital marketbasket (an inflation index of purchased goods and services) has risen by more than 28 percent since 1983, yet Medicare DRG payment rates have been increased by only 14.9 percent. This outcome is in stark contrast to the commitment of the prospective payment system (PPS) legislation to provide for annual inflation adjustments in hospital payments.

It is important to recognize that, while Medicare outlays in total are increasing, the hospital component of these expenditures is not the driving force. In the period 1985-89, Medicare inpatient payments on a per beneficiary basis declined in real terms at an annual rate of -0.6 percent. In fact, in the period 1980-88 Medicare spending for hospital services declined from 73 percent to 65 percent of total program spending. As noted earlier, Medicare payments for hospital services are increasing much less than the rate of increase in the hospital marketbasket, and far less than the 13.5 percent growth rate in the rest of Medicare. The three charts at the conclusion of this paper clearly illustrate these changes.

Payment reductions of this magnitude are unprecedented. More importantly, they have not occurred without consequences to all who depend on hospital services. Last year a record 81 hospitals closed, and over 400 hospitals have closed since 1982. Nearly 50,000 hospital beds have been eliminated since the advent of PPS. This year more than 50 percent of hospitals will actually lose money on the care they provide for Medicare patients, according to projections released by the Prospective Payment Assessment Commission (ProPAC). It is further estimated that the average hospital Medicare operating margin in FY 99 will be -11.5 percent should the Administration's budget proposals be enacted (Source: Consolidated Consulting Group).

MEDICAID REDUCTIONS

Although federal budget policies have recently avoided major reductions in the Medicaid program, in most states Medicaid hospital payments remain woefully inadequate. In 1984, according to a report of the House Committee on Energy and Commerce, Medicaid recipients used 11.6 percent of total days of inpatient hospital care and 12.7 percent of outpatient visits while the program accounted for only 8.8 percent of total hospital revenues.

Comparing average Medicaid per diem hospital payments with average hospital per diem costs in 1985, the report notes that 32 states pay rates less than average costs. Moreover, many states have imposed limitations on services for Medicaid recipients that affect the number of days or the types of admissions for which they will pay. In the period since 1980, Medicaid spending for hospital care has grown more slowly than the rest of Medicaid, increasing on average 8.6 percent per year, while total Medicaid spending has increased 10.1 percent. In sum, for most hospitals Medicaid payments are inadequate and likely to be getting worse.

COMPETITION IN THE PRIVATE MARKET

Private purchasers of health care services are aggressively seeking the lowest price, and consequently many hospitals have been forced to accept deep discounts against their customary rates. These discounts reflect the unwillingness of private purchasers to continue what they perceive as cost shifting and their subsidization of inadequate payment by Medicare and Medicaid and to cover the costs of care for unsponsored patients. By paying rates that reflect only the experience and cost of their own insured population, private purchasers have eroded hospitals' principal means of financing the care of patients with inadequate or no payment resources.

BURDEN OF UNCOMPENSATED CARE

Between 25 and 37 million Americans under the age of 65 lack health insurance. With the growth in the number of uninsured occurring at the same time as changes in payment strategies of private insurers and the federal government, it has become increasingly difficult for hospitals to shift the costs of treating the uninsured. Uncompensated hospital care nationally cost hospitals over $8.4 billion in 1986, six percent of total hospital costs. This figure understates hospitals' true burden because it does not include lower than cost reimbursement from the Medicare or Medicaid programs.

Our not-for-profit multi-hospital systems remain committed to providing needed health care services to the poor. Although our commitment remains intact, the dwindling resources available to hospitals to finance this care cause us concern.

OTHER STRESSES ON OUR NATION'S HOSPITALS

These national statistics on Medicare payment policies do not tell the full story of the impact of this sustained effort to cut hospital payments. Hospitals among our member systems have significantly reduced utilization while the full-time staff to patient ratio has increased, reflecting the growing severity of illness among current inpatients.

Institutions have also been forced to delay or abandon plans to modernize their facilities or to acquire new diagnostic and therapeutic modalities which offer advancements in patient care. The overall effects of these decisions are difficult to measure, but it is clear that compromises such as these will erode the quality and accessibility of hospital services to all our patients.

Two other payment policies have had a negative effect on hospitals: capital cost reimbursement and outpatient payments. For the past three years, payments for capital costs of hospitals have been arbitrarily reduced as a part of deficit reduction legislation. Currently capital payments are reduced by 15 percent across the board, and the Administration has proposed to increase the cut to 25 percent in FFY 1990. While some mistakenly believe these cuts will constrain future hospital capital investment, the reality is that these reductions largely impact fixed capital costs incurred in good faith by hospitals in the past. Reductions in these payments simply require hospitals to make further reductions in their operating budgets in order to service their overall financial obligations. In short, the effect of Medicare capital payment cuts is not confined to the hospital's capital budget, and reduces funds available to care for patients.

Another area that has been the target of repeated budget cutting is Medicare outpatient payments. Despite the intention under PPS to encourage hospitals to move services into the most economical setting, recent policy changes have been adopted that severely cut payments to hospitals for services regardless of where they are provided. These policies seem inconsistent with the stated intention of the incentives enacted under PPS. Furthermore, complex and fragmented billing procedures for outpatient services have been imposed on hospitals which frequently put them at a competitive disadvantage with freestanding ambulatory centers. Further reductions in these payments would only penalize hospitals for doing what was expected of them when the PPS legislation was enacted.

CONCLUSION

The AmHS Institute recognizes the magnitude of the economic and budgetary problems confronting the Congress and the Administration. However, it is vitally important that all policymakers recognize the changes which have already been enacted in Medicare hospital payment policy. Hospital payments have declined as a percentage of Medicare spending after decades of growth. We believe the hospital system has reached the limits of its ability to respond with further efficiencies without compromising the quality of patient care.

We, therefore, urge you to reject further cuts in hospital payments under Medicare in the FY 1990 budget.

TABLE 1
National Health Spending, Hospital Spending, and
the Gross National Product, Selected Years, 1965 - 1987

	Health Spending as % of GNP	Hospital Spending as % of Health Spending	Hospital Spending as % of GNP
1965	5.9 %	33.4 %	2.0 %
1970	7.4 %	37.3 %	2.8 %
1980	9.1 %	41.0 %	3.7 %
1981	9.4 %	41.5 %	3.9 %
1982	10.2 %	41.8 %	4.3 %
1983	10.5 %	41.1 %	4.3 %
1984	10.3 %	40.2 %	4.2 %
1985	10.4 %	39.8 %	4.2 %
1986	10.7 %	39.2 %	4.2 %
1987	11.1 %	38.9 %	4.3 %

Source: Health Care Financing Administration.

TABLE 2
Medicare Inpatient and Outpatient Hospital Spending,
Selected Years, 1975 to 1989 (estimated)
(In Millions of Dollars)

Spending	Total Medicare Benefits	Inpat. Hospital	Hospital Outpat. Hospital	Total Hospital	Other Medicare Benefits
1975	$14,118	$ 9,947	$ 530	$10,477	$ 3,641
1980	33,934	22,864	1,847	24,711	9,223
1985	68,576	44,075	3,903	47,978	20,598
1986	74,036	46,042	4,925	50,967	23,069
1987	79,736	46,697	5,793	52,490	27,246
1988e	85,584	48,250	6,795	55,045	30,539
1989e	93,329	51,083	8,097	59,180	34,149
Ave. Ann. % Increase					
1975 - 85	17.1 %	16.1 %	22.1 %	16.4 %	18.9 %
1985 - 89	8.0 %	3.8 %	20.0 %	5.4 %	13.5 %

Source: U.S. House Committee on Ways and Means. Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means. 1988 Edition.

TABLE 1
Annual Growth Rate in Medicare Inpatient Hospital Costs Per Enrollee, in Constant (1986) Dollars, Selected Years, 1970 - 1986

1970 - 1980 Average	2.3 %
1981	2.4 %
1982	0.5 %
1983	0.1 %
1984	-0.7 %
1985	-0.4 %
1986	-3.3 %
1981 - 1986 Average	-0.2 %

Source: U.S. General Accounting Office. Medicare and Medicaid; Updated Effects of Recent Legislation on Program and Beneficiary Costs, July, 1988.

STATEMENT OF THE ASSOCIATION OF HIGH MEDICARE HOSPITALS

This statement is submitted by the Association of High Medicare Hospitals (AHMH), an organization representing hospitals concentrating in the care of the aged. **AHMH members** have a Medicare utilization of 65 percent or more of total inpatient days. The Association welcomes this opportunity to present our views on Medicare hospital payment issues, because our analysis of Medicare hospital cost report data indicates that hospitals with a Medicare utilization of this magnitude have average Medicare operating margins considerably lower than those of hospitals with a lower level of Medicare utilization.

HIGH MEDICARE HOSPITAL CHARACTERISTICS

Based on Medicare hospital data, there are approximately 380 hospitals that meet the definition of high Medicare hospitals adopted by the Association, accounting for approximately 4.2 percent of total Medicare prospective payment revenues. About 30 percent of these hospitals are urban, and about 70 percent are rural. Of the urban high Medicare facilities, about 45 percent are under 100 beds, while about 54 percent have 100 to 404 beds. In the case of the rural high Medicare hospitals, about 96 percent of them have less than 100 beds.

High Medicare hospitals are found in all nine census regions. About 3 percent of these facilities are teaching hospitals, and about 5 percent currently qualify as hospitals serving a disproportionate share of low income patients.

PROBLEMS FACED BY HIGH MEDICARE HOSPITALS

Hospitals serving an unusually high proportion of Medicare beneficiaries are particularly vulnerable to the imprecision and limitations inherent in the present prospective payment system, which have been exacerbated by the recent budget constraints imposed on Medicare hospital payment.

Lower Average Medicare Margins

High Medicare hospitals have average Medicare operating margins significantly lower than those of all hospitals. Moreover, these margins are declining. For example, preliminary calculations indicate that in the third year of Medicare's hospital prospective payment system (PPS), i.e. hospital accounting years beginning October 1, 1985 through September 30, 1986, the average Medicare operating margin for all hospitals was 8.1 percent, while that for all high Medicare hospitals was 3.9 percent. Projections provided to the Association by the Consolidated Consulting Group -- based on the best information available at the time -- show average operating or "profit" margins in fiscal year 1987 for all hospitals of 6.9 percent compared to an average Medicare loss of 2.0 percent for all high Medicare hospitals.

Actual Medicare data and the projections for fiscal year 1987 reveal average Medicare operating margins for both the urban and rural high Medicare hospitals significantly lower than the respective margins [illegible] all urban or all rural hospitals. For example, projections for fiscal year 1987 show that average Medicare operating margins for urban high Medicare hospitals are 9.2 percentage points lower than for all urban hospitals (-1.0 percent for urban high Medicare hospitals vs. 8.2 percent for all urban hospitals), and that rural high Medicare hospitals have margins 3.6 percentage points lower than for all rural hospitals (-3.3 percent for rural high Medicare hospitals vs. 0.3 percent for all rural hospitals).

More Hospitals with Medicare Losses

Not only are average Medicare operating margins for high Medicare hospitals lower than those for all hospitals, but a larger proportion of high Medicare hospitals have suffered losses under

PPS compared to all hospitals. Actual Medicare data for PPS-3 show that 38 percent of all hospitals lost money under PPS while more than 56 percent of high Medicare hospitals operated at a loss under PPS. When more recent data become available, they are likely to show a further deterioration in the financial status of high Medicare hospitals, especially since, according to the Prospective Payment Assessment Commission, the hospital market basket -- reflecting the costs of goods and services purchased by hospitals -- increased by about 13.9 percent since PPS-3 while PPS payment rates have risen only about 6.1 percent.

Limited "Cost-Shifting" Opportunities

It is also important to note that, in view of their heavy reliance on Medicare revenues, high Medicare hospitals have a very limited ability to recover inadequately reimbursed Medicare costs from other sources, including other payors. Obviously, in a time of intense competitiveness in the provision of hospital services, high Medicare hospitals cannot simply pass along Medicare losses to the relatively small number of non-Medicare patients, expecting other payors to willingly shoulder these Medicare shortfalls.

RELIEF SOUGHT

The AHMH has met with officials of the Health Care Financing Administration (HCFA) and with the Prospective Payment Assessment Commission (ProPAC) to discuss our concerns. The Association has urged both HCFA and the Commission to devote some of their analytic resources to examining the problems of high Medicare hospitals. Specifically, we have indicated our belief that data and analysis relating to high Medicare hospitals should be included in regulatory impact statements accompanying PPS rules and other proposed hospital payment regulations. Also, the regular reports to the Congress about the impact of PPS prepared by HCFA and ProPAC should include an examination of high Medicare hospitals, much in the same way that these reports consider the impact on other special classes of hospitals, such as those serving a disproportionate share of low income patients.

In its March 1, 1989 report, the Prospective Payment Assessment Commission noted the concerns that have been raised about the vulnerability of hospitals with high Medicare utilization and indicated that it "...plans to monitor the relationship between the proportion of Medicare patients and financial performance under PPS."

The Association believes that the worsening financial position of high Medicare hospitals argues for a change in the PPS payment methodology that would treat these facilities more equitably. We welcome the fact that several bills introduced early in the 101st Congress include provisions recognizing that certain "Medicare-dependent" rural hospitals warrant special protection under Medicare's hospital payment system. However, these bills focus solely on the problems of small, rural Medicare-dependent hospitals, while the AHMH believes that the current PPS also disadvantages urban and larger rural high Medicare hospitals as well. We also note that our definition of high Medicare hospitals makes use of inpatient days, rather than some other measure of utilization, in a manner not unlike that chosen by the Congress in identifying hospitals serving a disproportionate share of low income patients.

The Association recommends that the Congress address the problems of all high Medicare hospitals (i.e. all hospitals with Medicare utilization of 65 percent or more of total inpatient days). For urban high Medicare hospitals, we recommend a per case adjustment based on the difference between the average Medicare operating margin of urban, high Medicare hospitals and all urban hospitals. Similarly, we recommend a per case adjustment for rural high Medicare hospitals based on the margin differential between this class of rural hospitals and all rural facilities. To illustrate, if the latest available Medicare data showed a 5 percentage point difference between the average Medicare operating margin for urban high Medicare hospitals and all urban hospitals, the approach recommended by the Association would result in a 5 percent upward adjustment in Medicare payment amounts for the high Medicare facilities.

We believe that such a payment adjustment would help assure that hospitals concentrating in the treatment of Medicare beneficiaries would be treated more equitably than they are under current hospital payment rules.

We look forward to working with the Committee as it grapples with the problems faced by the nation's hospitals, including high Medicare facilities. We would be pleased to provide any additional information that would be helpful.

STATEMENT OF BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Blue Cross and Blue Shield Association appreciates this opportunity to submit comments for the record regarding Fiscal 1990 Medicare Hospital payment issues. Blue Cross and Blue Shield Plans, in their role as intermediaries, adjudicate virtually all Medicare hospital claims.

Medicare Hospital Payment Rate Adequacy

We believe that Medicare should not be subject to a disproportionate share of the deficit reduction burden. Since 1983, Medicare has accounted for a disproportionate amount of deficit-reduction savings. We also believe that Congress should provide for a Medicare budget in FY 1990 that assures continued access to high quality health care for Medicare's 33 million beneficiaries and does not threaten the financial soundness of the nation's health care delivery system.

The basic principle of Medicare's hospital Prospective Payment System (PPS) - to encourage efficiency by setting a prospective fixed price - continues to be sound. However, the Prospective Payment Assessment Commission (ProPAC) has noted that certain classes of hospitals, particularly those in rural and inner-city areas, tend to incur financial losses on Medicare patients, while other hospitals, particularly teaching facilities, generally are profiting. Medicare's purpose is to provide adequate beneficiary access to care, not to maintain inefficient hospitals or excess hospital capacity. Nevertheless, where entire classes of hospitals suffer Medicare losses, this does endanger beneficiary access. It also suggests that a hospital's financial position under Medicare is affected by its locale and service characteristics as well as its relative efficiency.

Therefore, we believe Congress's primary attention on rate adequacy should be focused on setting a "level playing field" for all classes of hospitals. This can be accomplished by fine-tuning the existing PPS system. Adjustments already in place could be extended and made more precise. New adjustments may also be needed.

We continue to believe an accurate severity adjuster would help resolve problems of many hospitals, but that such an approach is not viable in the short term. Thus, we support in principle the proposal of the American Hospital Association (AHA) that further refinements be made in those DRGs that have highly variable costs. We also look forward to the March 31 Yale report to HCFA on DRG refinement.

Timely, Accurate Medicare Cost Report Data for PPS Policymaking and Program Savings

We agree with ProPAC that timely, accurate Medicare hospital Cost Report data is essential to informed PPS policymaking. We thus support ProPAC's concern about cuts in intermediary audit funding. Any cut, such as the 50 percent reduction proposed by the Administration's Fiscal Year 1990 budget, would impede the development of timely, accurate Medicare Cost Report data needed for informed policymaking. The Administration's proposal would virtually eliminate all indepth financial audits of hospital cost reports. This means review would be solely limited to mathematical checks without the ability to verify actual costs. This would be like IRS just simply running mathematical checks on tax returns with no ability to audit tax payer records. It also would jeopardize implementation of the OBRA-87 provision, introduced by Chairman Stark, for the development of a hospital cost data base and standardized electronic cost reporting.

Adequate funding for intermediary audit and other payment safeguards also is a cost-effective investment in minimizing unnecessary Medicare spending. The Administration's Fiscal 1990 budget proposal would reduce payment safeguards funding by $134 million, thereby causing an estimated $1.1 billion in unnecessary benefit payments, according to the U.S. General Accounting Office. Therefore, we urge the Subcommittee to recommend to the Appropriations Committee that it support adequate funding for this cost-effective activity. We believe a total Fiscal 1990 funding level for payment safeguards of $423.7 million is necessary, including $190.4 million for utilization review, $154.9 million for audit and $78.4 million for Medicare Secondary Payer activities.

Medicare Capital Payments

We continue to support a phased inclusion of hospital capital costs into DRG rates as soon as feasible. However, we do not have a specific phase-in proposal, and we recognize that several policy and technical issues would need to be resolved. In particular, equitable treatment for hospitals at different points in the capital replacement cycle would need to be devised. We also would note that a phase-in would link capital payments to occupancy because each DRG admission payment would include a capital component. We would note that special treatment of under-capitalizaed hospitals, such as rural and inner-city facilities, might be necessary under this approach.

If Congress is unable to devise a viable method to phase capital into DRG rates, other options, such as linking capital payment amounts to occupancy-rate targets for various types of hospitals, should be explored. We look forward to working with Congress as it considers approaches to this issue.

We believe the Administration's proposed 10 percent additional cut in capital for every hospital, to a reimbursement level of 75 percent of allowable costs, is not appropriate. This proposal does not differentiate between efficient and inefficient hospitals. Moreover, it would severely affect those hospitals that are in need of renovation to meet Medicare's conditions of participation. In addition, many hospitals that are essential to beneficiary access to care will be unable to absorb an additional reduction.

Medicare Payments for Indirect Medical Education

Medicare currently pays teaching hospitals a 7.7% add-on to their DRG rates as compensation for "indirect" costs of medical education. Congress has long been aware that this adjustment overstates actual costs. Recent estimates of the appropriate adjustment factor by ProPAC and GAO range from 4.4 to 5 percent, while the Administration's budget would reduce it to 4.05 percent. We agree that a reduction of the "indirect" adjustment to the level that is justified by econometric studies is appropriate. While we have not done an independent analysis of the appropriate amount, the issue is balancing technical concerns with the impact on hospitals. The ProPAC concept of phased-in reduction is appropriate because it allows hospitals to plan.

Rural Hospital Issues

We recognize that rural hospitals face special circumstances. The closure of rural hospitals often poses a greater threat to beneficiary access to care than is the case in urban areas. Rural hospital closures also may increase Medicare costs if beneficiaries are forced to use hospitals in more highly-paid urban areas. Finally, small rural hospitals are unable to reap efficiencies of size or scale. Therefore, we believe it is appropriate to consider extending the current differential rate update factors between rural and urban hospitals.

We believe that AHA's proposal to permit rural hospitals with less than 50 beds to opt out of PPS deserves consideration. Because a hospital of this type treats few Medicare patients, it cannot take advantage of PPS averaging of financially profitable and unprofitable cases. A single high-cost case can be financially devastating for small rural hospitals, so a cost-based system may be appropriate. However, permitting hospitals to select their payment system could result in increased Medicare spending because hospitals would choose the most advantageous system. This proposal also would not guarantee that exempt hospitals would survive financially, and could encourage continued operation of inefficient and unnecessary facilities.

For hospitals not permitted to opt out of PPS, AHA's proposal for a single national rate per DRG with a hold-harmless provision is an approach that deserves further study and consideration. The key issue here is whether the cost structure of rural and urban hospitals continues to be sufficiently different to warrant separate rate classes and whether the increased Medicare outlays associated with a hold-harmless provision can be offset by other program savings.

Wage Index

We continue to agree with ProPAC and the American Hospital Association (AHA) that changes to the hospital wage index are needed to provide greater equity. More recent data is needed, and we support HCFA's intention to move to biennial updates. We also believe that greater emphasis should be placed on hospital industry wages.

Conclusion

In summary, we recommend that:

- Medicare should not be subject to a disproportionate share of the deficit reduction burden.
- Congressional action should focus on assuring fair payment for all classes of hospitals. Because different types of hospitals have different levels of PPS financial performance, action should concentrate on adjustments by class of hospital.
- The indirect medical education adjustment should be reduced, and payment for capital costs should be addressed in the near term, by phasing capital into PPS.
- Other important changes would be implementation of a valid severity adjustment or other approach to recognizing the high cost variability of certain DRGs, and improvement of the wage index.
- Congress approve adequate funding for Medicare intermediary and carrier functions, which include provider audits and other cost-effective payment safeguards.

We look forward to working with the Subcommittee as you consider the important and difficult issues posed by the need to achieve budget savings while maintaining Medicare beneficiary access to essential hospital care.

2135S

STATEMENT OF THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

This statement is submitted on behalf of the National Association of Rehabilitation Facilities (NARF). NARF is the principle national membership organization of community-based medical and vocational rehabilitation facilities. A substantial number of NARF members are freestanding rehabilitation hospitals and rehabilitation units in general hospitals. These members are facilities that are excluded from the Medicare prospective payment system (PPS). They are reimbursed under the Medicare program on the basis of cost reimbursement limited by ceilings known as TEFRA target rate ceilings. We welcome this opportunity to submit comments for the record on the effect of the PPS on excluded facilities and hospital payments under the Medicare program for fiscal year 1990.

I. FY 1990 UPDATE

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) recognized the need for a separate annual update factor for all facilities excluded from the PPS. The Secretary of the Department of Health and Human Services (HHS) is required by law to set this update for excluded facilities for FY 1990 and subsequent fiscal years at the level of the market basket mix of hospital goods and services. The market basket reflects the increase in inflation for inpatient hospital goods and services.

NARF recommends that the excluded rehabilitation hospitals and units receive the full market basket as the update for fiscal year 1990, corrected for previous forecasting errors. As you will note in the report of the Prospective Payment Assessment Commission (ProPAC), ProPAC historically has supported a separate update factor for such excluded facilities. ProPAC recommends that the update for FY 1990 be the full market basket plus a correction for market basket forecast errors from previous years. This figure is 6.2%. NARF supports this recommendation.

Excluded rehabilitation facilities should receive the full market basket for several reasons. First, such hospitals and units receive no other adjustment under the PPS on an annual basis. The only possible increase for payments to these facilities is the increase in the annual target rate per discharge. PPS hospitals, however have other adjustments available to them, such as changes in coding. If excluded facilities' costs exceed their target ceiling limitation, they do not receive additional reimbursement under Medicare, unless they file for an exception or adjustment to the limitation and the Health Care Financing Administration (HCFA) grants such relief. The process for applying and obtaining such relief is retrospective in application only and lengthy in terms of the time it takes to obtain relief.

Second, a separate update for excluded facilities continues to be required because the labor costs and the impact of the PPS on such facilities are considerably different from those of the PPS hospitals. Currently the labor costs of excluded rehabilitation hospitals and units exceeds 64%. Equally as important, the PPS has resulted in patients being admitted to excluded rehabilitation hospitals and units sicker and quicker. A recent National Rehabilitation Hospital, Washington, D.C., study showed increased acuity of patients admitted for rehabilitation since the start of the PPS. Approximately two-thirds of the respondents in that study reported increased nursing hours per patient day, reduced functional status measures, increased therapy, reduced time from onset to admission and similar indicators.

These factors suggest serious examination of a separate market basket specifically for rehabilitation. NARF currently is surveying its members to determine current labor costs as a percentage of total expenses and the rate at which the cost of services, particularly nursing and therapy costs are increasing. Those rates of change seem to be in excess of similar costs in PPS hospitals. This discrepancy should be recognized in a separate market basket for rehabilitation providers.

As noted, personnel costs in rehabilitation hospitals and units currently exceeds 64% of their total costs. This compares with an average of slightly less than 57% for PPS hospitals. Preliminary analyses of the first set of NARF survey respondents shows that rehabilitation hospitals and units continue to have a similar level of labor costs (salaries, wages and fringe benefits) if not several percentage points higher than that found in previous surveys.

This higher percentage of facility costs associated with personnel is also significant in looking at salary trends for the types of personnel related to rehabilitation specifically physical therapists, occupational therapists, and rehabilitation nurses. These specialists are in short supply. Consequently, there is considerable competition to recruit and retain these personnel, resulting in higher salaries and recruitment costs. A NARF 1986 sample of 18 rehabilitation hospitals reported that for the then two most recently completed fiscal years ('85 to '86), the cost for physical therapy services increased by over 7.1%; occupational therapy by 6.6%; and rehabilitation nursing by 5%. These figures were higher than other national data compiled by the University of Texas which shows the mean maximum rate of change from '85 to '86 for maximum salary rates for registered nurses to be 5.46%; for physical therapists to be 4.46%; and for occupational therapists to be 5.66%. As mentioned, NARF is in the process of calculating data for earlier and later years.

A second area showing an increase in costs for rehabilitation facilities is in medical supplies. The same 1986 NARF survey referenced above indicated an increase of 27.4% in the cost of medical supplies for the '85 to '86 period. This is probably a function of earlier patient transfers to rehabilitation facilities, partly because of the incentives in the PPS to discharge patients earlier. Data from a small sample of hospitals that have applied to HCFA for exception and adjustment relief have shown that the time of patient referral from a PPS hospital to rehabilitation from onset of the disability has dropped dramatically. An earlier referral, while beneficial to the clinical needs of patients and their rehabilitation potential, usually means a sicker patient.

Finally, NARF recommends that there be no reductions to the market basket along the lines of policy target adjustment factors (PTAFs) as utilized previously by HHS. Excluded rehabilitation hospitals and units in the past were subject to reductions in the market basket for these PTAFs for factors that had absolutely no bearing upon excluded rehabilitation hospitals and units. These PTAFs included, for example, changes in practice patterns, site substitution, changes in case mix, productivity and the like.

Rehabilitation hospitals and units are experiencing substantially higher per discharge costs because of the sooner and sicker phenomenon as noted above. To the extent that changes in practice patterns affect per discharge costs the changes that resulted from the PPS tend to increase them. Excluded rehabilitation hospitals and units are the site to which the PPS patient has been substituted. Additionally, case mix changes that have occurred generally show increased, not decreased, severity. An early unpublished study done by ProPAC showed a considerable increase in case mix. The TEFRA system does not acknowledge changes in case mix on a positive or negative basis. Thus, excluded hospitals are not able to increase revenues by upgrading their case mix through coding, commonly known as "DRG creep".

II. STREAMLINING THE EXCEPTION AND ADJUSTMENT PROCESS

Currently, the only relief available to a rehabilitation facility which has exceeded its target ceiling limitation, for legitimate reasons related to patient care, is the administrative exceptions and adjustment process. The regulations governing this process were published pursuant to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and have not been amended since.

To summarize the process, once a provider has completed a cost reporting period and its Medicare costs exceed its TEFRA target rate, the facility can apply for exception or adjustment relief. It sends an application with supporting material to its fiscal intermediary (FI). The FI verifies the information and sends it to HCFA in Baltimore. Once HCFA receives a complete file, it has

180 days to analyze the application and come to a decision. This time period can take longer if the file is incomplete or additional information is required from the provider.

We estimate that currently, it takes a minimum of 12-14 months after the cost report is completed, not even audited by the FI, to analyze, draft and process an application for relief. This is particularly rough on rehabilitation hospitals and units, especially those which have had an increase in the severity of the cases they are serving resulting in longer lengths of stay, e.g., more severe strokes. Also costs may increase above the limits if the facilities serve increased numbers of certain types of severe cases with longer lengths of stay, e.g., more head injuries, spinal cord injuries and strokes, etc.

In the Family Support Act of 1988, the Conference report expressed interest in this process and its impact on these hospitals with long lengths of stay. It stated "the conferees expect the Secretary, in granting exemptions..., will take into account the increases in length of stay in PPS exempt hospitals." We recommend that the Committee reiterate its interest in this area.

NARF has been holding a series of discussions with HCFA and has provided recommendations on how the current relief process can be accelerated to the benefit of all involved. These recommendations include placing timelines on FI actions and allowing FIs to make certain determinations on applications subject to very clear guidelines. Application would also continue to be reviewed at the HCFA national office. To date these recommendations have been well received by HCFA and we will continue to pursue them.

This statement addresses only issues assuring that excluded hospitals obtain the maximum update as allowed by law and accelerating the exceptions and adjustment relief process. The TEFRA system itself has significant defects, with serious consequences for excluded rehabilitation hospitals and units. Most of these defects pertain to the lack of the system's ability to recognize changes in case mix, severity or higher costs associated with longer lengths of stay and/or more intense care. These are issues which we will address to the Committee in a separate paper.

If you have any questions, please feel free to contact me.

Carolyn Zollar, Esq.
General Counsel

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

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My name is James Roosevelt. As Chairman of the National Committee to Preserve Social Security and Medicare, I represent the organization's more than five million members and supporters, seventy-five percent of whom are over age 65 and dependent on Medicare. The National Committee is deeply concerned that inadequate Medicare reimbursement to hospitals will result in a decline in quality of care and reduced access to health care, particularly in rural areas.

> **The National Committee urges Congress to accept the ProPAC recommendations for increases in hospital rates. ProPAC's proposals are independent recommendations based on health policy, not the indiscriminate cuts proposed by the Administration merely for the sake of reducing the deficit. The National Committee continues to recommend the development of a severity of illness index and the elimination of the lower reimbursement rate for rural hospitals.**

COST CONTAINMENT

Since the early years of the prospective payment system (PPS), hospitals have been the main target for Medicare budget cuts. Clearly a 14 percent profit margin in 1984 and 1985, the first two years of PPS, was excessively high. However, according to the Medicare Prospective Payment Assessment Commission (ProPAC), the profit margin has rapidly declined, from eight percent in 1986 down to zero last year. This year, we may well see losses. Furthermore, since the financial picture varies greatly between types of hospitals, some categories of hospitals are working with profit margins considerably lower than average. In light of this, we are troubled by the Administration's proposal to cut Medicare reimbursements to hospitals by a total of $2.4 billion in 1990. While the National Committee is committed to aggressive cost containment and to finding ways to make our health care system as efficient as possible, the report on hospital profit margins is a serious warning signal which deserves keen attention. Some hospitals with a poor financial performance may have only themselves to blame. Others are victims of flaws in the reimbursement system -- flaws which also affect Medicare beneficiaries.

We agree that reimbursements for medical education and capital expenses need to be reduced. But we are not convinced that the Administration's solution is adequate. Slashing direct medical education reimbursements could seriously hurt inner-city teaching hospitals caring for seriously ill poor seniors. As for capital reimbursement, rather than an arbitrary 10 percent additional cut, Congress should include capital costs in the prospective payment system.

QUALITY OF CARE

Under the prospective payment system, patients are released from the hospital as soon as the physician judges their condition is stabilized. An American Medical Association survey shows that many physicians feel pressured by hospitals to discharge patients as quickly as possible. In October of 1987, the Subcommittee on Human Resources and Intergovernmental Relations of the Committee on Government Operations reported that poor hospital care may be responsible for as many as 393,800 cases of "inadequate discharge planning" and 22,000 "avoidable deaths" among Medicare patients each year. Cutting Medicare means that even more pressure will be placed on physicians to release patients as soon as they become liabilities to financially struggling hospitals.

A disturbing pattern of deteriorating care for Medicare patients with hip fractures was revealed in a study published last November in the New England Journal of Medicine. Researchers linked the deterioration to Medicare hospital cost-cutting efforts begun in 1984. Before-and-after comparisons showed the average length of stay for a hip fracture was shortened from 21.9 to 12.6 days, and physical therapy sessions were cut from eight to six. Discharges to nursing homes rose, and the number of patients still there after one year more than tripled. To quote the researchers, "We conclude that since the implementation of PPS, hospitals have reduced the amount of care given to patients with hip fracture and have shifted much of the rehabilitation burden to nursing homes. The increase in the number of such patients remaining in nursing homes one year after the fracture suggests that the overall quality of care for these patients may have deteriorated."

While somewhat shorter stays should be expected under the prospective payment system, it is imperative that the quality of care be maintained. If hospital reimbursement reflected the severity of the patient's illness, a premature discharge would be less likely. Two years ago, Congress asked the Health Care Financing Administration to recommend a method to incorporate severity of illness into the diagnosis related groups. That final report is overdue. The quicker the Administration and Congress act on adjusting the DRG's, the sooner beneficiaries can be better assured of quality care.

ACCESS TO CARE

Last year, 81 community hospitals closed -- more than half of these in rural areas. That brought the total hospital closings to 445 since 1980, a rate of hospital closings triple that found prior to the implementation of PPS.

When a local hospital closes, seniors -- indeed all health care users -- suffer because they must travel greater distances to receive treatment. Long distances add to problems of early release from hospitals. Not only can the trip itself be a hardship on a patient who is barely stable after surgery, but should an emergency occur, the time factor in a long ambulance ride could be life-threatening.

Small rural hospitals are particularly vulnerable to the mix of patients. A few costly cases can financially ruin a hospital with a low volume. Sometimes, this can cause a hospital to be very selective in whom they admit. A struggling hospital may try to avoid admitting frail seniors whose multiple chronic conditions prolong their recovery from acute conditions.

There is a 14.5% differential between urban and rural hospital payments, according to a Senate Aging Committee report. This significant difference should be eliminated. Congress has begun this process, but unless this trend moves faster, rural areas will not be able to attract highly skilled hospital personnel. Another important reason to protect against the further demise of rural hospitals is the fact that hospitals attract physicians to an area. Without a hospital, physicians may not want to practice in that particular geographic area. This would further exacerbate the problem of beneficiaries' limited access to health care.

CONCLUSION

The National Committee believes that the Administration's budget proposal cuts far too deeply into Medicare reimbursements of hospitals. Such severe cuts will ultimately affect the quality of care and beneficiaries' access to health care. We urge Congress to limit the reductions and to adopt the ProPAC recommendation for hospital rate increases.

O